

may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9 Film G225 2-25-58 et

713

## CERTIFICATE OF DEATH

00708

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>	
f. STREET ADDRESS <b>220 N. Union Ave.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>STEEL</b> Middle <b>R.</b> Last <b>BARNES</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>24</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1/27/1880</b>
9. AGE (In years lost birthday) yrs. <b>78</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>24</b> Hours <b>1</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11c. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>J. LEWIS RUSSELL</b>		14. MOTHER'S MAIDEN NAME <b>Julia Josephine Boyd</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unknown</b>	
17. INFORMANT <b>Hosp. Friends, Harde Shaw Md.</b>		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myo cardiac infarction</b> DUE TO <b>pericardial effusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive - arterio-sclerotic heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/20</b> , 19 <b>58</b> , to <b>1/24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1/23</b> , 19 <b>58</b> , and that death occurred at <b>130 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. H. Weissman</b>		ADDRESS (Street, city or town, state) <b>Harde Shaw Md</b>	
DATE <b>1/24/58</b>		DATE SIGNED <b>1/24/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. H. Weissman</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>1/26/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Harde Shaw Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Funeral Home, Harde Shaw Md.</b>		24a. REC'D BY REGISTRAR <b>AN 2 8 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>			

CERTIFICATE OF DEATH

DATE OF DEATH

DECEASED

PLACE HERE THE NAME OF THE DECEASED

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BUREAU V. S.

JAN 28 1938

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas H. Berry</u>		4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 Feb. 1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber/Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Berry</u>		14. MOTHER'S MAIDEN NAME <u>Lena Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>4200</u>	
17. INFORMANT <u>Ruth R. Berry</u>		Address <u>42 Church St. Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarct</u> DUE TO (c) <u>Arteriosclerotic Heart Dis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>4 hr.</u> <u>2 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-27-</u> , 19 <u>57</u> , to <u>1-10-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-10-</u> , 19 <u>58</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D.		ADDRESS (Street, city or town, state) <u>8 Law St. Aberdeen, Md.</u>	
DATE SIGNED <u>1-10-58</u>			
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>R.D. Aberdeen, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		ADDRESS <u>Aberdeen, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Q. Leach</u>	

# CERTIFICATE OF DEATH

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM 10

FILE NO.

DATE OF DEATH

DECEASED

PLACE HERE THE NAME OF THE DECEASED

PLACE HERE THE ADDRESS OF THE DECEASED

DATE OF BIRTH

SEX

NAME OF DECEASED

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BUREAU V. S.

JAN 14 1908

RECEIVED

FILE NO.

DATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

715

CERTIFICATE OF DEATH

Reg. Dist. No.

00710

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE 24</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>				d. STREET ADDRESS <u>116 BAY BLVD.</u>			
3. NAME OF DECEASED (Type or print) First <u>FRANCES</u> Middle <u>F</u> Last <u>BRESS</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1892</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWf.</u>		11. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWf.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>			
13. FATHER'S NAME <u>MOSES FREEMAN</u>				14. MOTHER'S MAIDEN NAME <u>JENNIE GEUNTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Jensel Bress - 740 Tydings Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Cancer Lesions - Cardio Vascular failure</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of the <del>Colon</del> LUNG</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Sept.</u> , 19 <u>57</u> , to <u>Jan. 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan. 9</u> , 19 <u>58</u> , and that death occurred at <u>3:10</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Günther D. Hirsch</u>				DATE SIGNED <u>1/10/58</u>			
PHYSICIAN'S NAME (Type) <u>GÜNTHER D. HIRSCH</u>				ADDRESS (Street, city or town, state) <u>421 CONGRESS AVE. HAURE DE GRACE MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 12/58</u>		<u>Hebrew Friendship</u>		<u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
DATE <u>AN 1 4 '58</u>				<u>Deedman</u>			



CERTIFICATE OF DEATH

1-1-58

4-1-58

BUREAU V. 1

JAN 14 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00711

1. PLACE OF DEATH a. COUNTY <u>Hagerstown</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>W.H. &amp; S. 46</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Whiteford</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MD Route 136</u>		d. STREET ADDRESS <u>RD</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Lane</u> Last <u>Boyle</u>		4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 23, 1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>58</u> Days <u>58</u>	IF UNDER 24 HRS. Hours <u>58</u> Min. <u>58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEWING-MACHINE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>	11. BIRTHPLACE (State or foreign country) <u>York Co., Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM LANE</u>	
14. MOTHER'S MAIDEN NAME <u>ZULA BOYD</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>166-12-4811</u>		17. INFORMANT <u>HUGH BOYLE, WHITEFORD, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury head</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>812X</u> DUE TO (c) <u>812X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auto accident - Auto-pedestrian type</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - Auto-pedestrian type</u>		20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> o. m. <u>1-3</u> 58 a. m. <u>1-3</u> 58	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>MD Route 136 Whiteford Hagerford MD</u>	
20f. (City or town) <u>Whiteford</u>		20g. (County) <u>Hagerford</u>	
20h. (State) <u>MD</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bolton, MD</u> DATE SIGNED <u>1-3-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
22b. DATE THEREOF <u>1-7-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TABERNACLE</u>	
22d. LOCATION (City, town, or county) <u>WHITEFORD, MD.</u>		22e. (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins, Delta, Pa.</u>		ADDRESS <u>Delta, Pa.</u>	
24a. REC'D BY REGISTRAR <u>ON 6</u>		24b. REGISTRAR'S SIGNATURE <u>U. H. Harkins</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 6 1909

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00712

716

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CECIL</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PORT DEPOSIT</b> 07X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSP.</b>		d. STREET ADDRESS <b>23 High</b>	
3. NAME OF DECEASED (Type or print) <b>BENNER C Charsha</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>3</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-10-1900</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>OLIVER CHARSHA</b>	
14. MOTHER'S MAIDEN NAME <b>RHODA NESBITT</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>214-01-7988</b>		17. INFORMANT <b>Mrs. Alice Charsha, 23 High St. Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Secondary Anemia</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemorrhage - biopsy site (pelvis)</b> DUE TO (c) <b>Carcinomatosis - primary - lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 16, 1957</b> , to <b>Jan. 3, 1958</b> , that I last saw the deceased alive on <b>Jan. 3, 1958</b> , and that death occurred at <b>11:25</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. H. Sadowsky</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>6005 Union Av., Harford, Md. 1/4/58</b>	
PHYSICIAN'S NAME (Type) <b>W. H. Sadowsky M.D.</b>			
22a. BURIAL, CREMATION, REBURY (Type)	22b. DATE THEREOF <b>1-6-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. A. Patterson &amp; Son</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 7 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Sadowsky</b>

CERTIFICATE OF DEATH

FILE NO.

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of anatomist	
22. Signature of bacteriologist		23. Signature of virologist		24. Signature of epidemiologist	
25. Signature of public health nurse		26. Signature of health visitor		27. Signature of sanitarian	
28. Signature of health officer		29. Signature of coroner		30. Signature of jury	
31. Signature of medical examiner		32. Signature of pathologist		33. Signature of anatomist	
34. Signature of bacteriologist		35. Signature of virologist		36. Signature of epidemiologist	
37. Signature of public health nurse		38. Signature of health visitor		39. Signature of sanitarian	
40. Signature of health officer		41. Signature of coroner		42. Signature of jury	
43. Signature of medical examiner		44. Signature of pathologist		45. Signature of anatomist	
46. Signature of bacteriologist		47. Signature of virologist		48. Signature of epidemiologist	
49. Signature of public health nurse		50. Signature of health visitor		51. Signature of sanitarian	
52. Signature of health officer		53. Signature of coroner		54. Signature of jury	
55. Signature of medical examiner		56. Signature of pathologist		57. Signature of anatomist	
58. Signature of bacteriologist		59. Signature of virologist		60. Signature of epidemiologist	
61. Signature of public health nurse		62. Signature of health visitor		63. Signature of sanitarian	
64. Signature of health officer		65. Signature of coroner		66. Signature of jury	
67. Signature of medical examiner		68. Signature of pathologist		69. Signature of anatomist	
70. Signature of bacteriologist		71. Signature of virologist		72. Signature of epidemiologist	
73. Signature of public health nurse		74. Signature of health visitor		75. Signature of sanitarian	
76. Signature of health officer		77. Signature of coroner		78. Signature of jury	
79. Signature of medical examiner		80. Signature of pathologist		81. Signature of anatomist	
82. Signature of bacteriologist		83. Signature of virologist		84. Signature of epidemiologist	
85. Signature of public health nurse		86. Signature of health visitor		87. Signature of sanitarian	
88. Signature of health officer		89. Signature of coroner		90. Signature of jury	
91. Signature of medical examiner		92. Signature of pathologist		93. Signature of anatomist	
94. Signature of bacteriologist		95. Signature of virologist		96. Signature of epidemiologist	
97. Signature of public health nurse		98. Signature of health visitor		99. Signature of sanitarian	
100. Signature of health officer		101. Signature of coroner		102. Signature of jury	

1-10-1900

Registration

1-10-1900, 1-10-1900, 1-10-1900

BUREAU V. S.

JAN 7 1900

RECEIVED

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of anatomist	
22. Signature of bacteriologist		23. Signature of virologist		24. Signature of epidemiologist	
25. Signature of public health nurse		26. Signature of health visitor		27. Signature of sanitarian	
28. Signature of health officer		29. Signature of coroner		30. Signature of jury	
31. Signature of medical examiner		32. Signature of pathologist		33. Signature of anatomist	
34. Signature of bacteriologist		35. Signature of virologist		36. Signature of epidemiologist	
37. Signature of public health nurse		38. Signature of health visitor		39. Signature of sanitarian	
40. Signature of health officer		41. Signature of coroner		42. Signature of jury	
43. Signature of medical examiner		44. Signature of pathologist		45. Signature of anatomist	
46. Signature of bacteriologist		47. Signature of virologist		48. Signature of epidemiologist	
49. Signature of public health nurse		50. Signature of health visitor		51. Signature of sanitarian	
52. Signature of health officer		53. Signature of coroner		54. Signature of jury	
55. Signature of medical examiner		56. Signature of pathologist		57. Signature of anatomist	
58. Signature of bacteriologist		59. Signature of virologist		60. Signature of epidemiologist	
61. Signature of public health nurse		62. Signature of health visitor		63. Signature of sanitarian	
64. Signature of health officer		65. Signature of coroner		66. Signature of jury	
67. Signature of medical examiner		68. Signature of pathologist		69. Signature of anatomist	
70. Signature of bacteriologist		71. Signature of virologist		72. Signature of epidemiologist	
73. Signature of public health nurse		74. Signature of health visitor		75. Signature of sanitarian	
76. Signature of health officer		77. Signature of coroner		78. Signature of jury	
79. Signature of medical examiner		80. Signature of pathologist		81. Signature of anatomist	
82. Signature of bacteriologist		83. Signature of virologist		84. Signature of epidemiologist	
85. Signature of public health nurse		86. Signature of health visitor		87. Signature of sanitarian	
88. Signature of health officer		89. Signature of coroner		90. Signature of jury	
91. Signature of medical examiner		92. Signature of pathologist		93. Signature of anatomist	
94. Signature of bacteriologist		95. Signature of virologist		96. Signature of epidemiologist	
97. Signature of public health nurse		98. Signature of health visitor		99. Signature of sanitarian	
100. Signature of health officer		101. Signature of coroner		102. Signature of jury	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

739

## CERTIFICATE OF DEATH

00713

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: residence before admission) a. STATE <i>Pennsylvania</i> b. COUNTY <i>Philadelphia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>New Hanover</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Have de Grace. Ed. P. D.</i>	
c. LENGTH OF STAY IN 1b <i>4 month</i>		d. STREET ADDRESS <i>Chapel Road</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>no</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Robert</i> First <i>Peter</i> Middle <i>Clees</i> Last		4. DATE OF DEATH Month <i>1</i> Day <i>2</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 10 1888</i>
9. AGE (In years last birthday) <i>69</i> yrs		IF UNDER 1 YEAR Months <i>6</i> Days <i>9</i> Hours <i>15</i> Min.	IF UNDER 24 HRS Hours <i>15</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dairy</i>	
11. BIRTHPLACE (State or foreign country) <i>Astoria I.I. NY</i>		12. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>	
13. FATHER'S NAME <i>George Clees</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO <i>None</i>	
17. INFORMANT <i>Daughter</i>		Address <i>Have de Grace Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cancer of Prostate, Generalized - 177x</i> DUE TO (b) <i>Arterio Sclerotic Heart Disease</i> DUE TO (c) <i>18 month</i>			INTERVAL BETWEEN ONSET AND DEATH <i>18 month</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 3</i> , 19 <i>57</i> , to <i>January 21</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>December 15</i> , 19 <i>57</i> , and that death occurred at <i>3:18</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Andrie' Vem</i> M.D.		ADDRESS (Street, city or town, state) <i>17 N. Phila. Blvd., Aberdeen Md</i>	
PHYSICIAN'S NAME (Type) <i>ANDRE WEISS MD</i>		DATE SIGNED <i>1.2-58</i>	
22a. BURIAL, CREMATION, or other disposal (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/6/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Francis De Sales</i>		22d. LOCATION (City, town, or county) (State) <i>Elkton Park N.Y.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Concepcion R. Hand</i>		24a. REC'D BY REGISTRAR <i>JAN 6</i>	
24b. REGISTRAR'S SIGNATURE <i>W. M. M. M.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. DEPARTMENT OF AGRICULTURE

1910-1911

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00714

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD 2 Box 175</u>		e. STREET ADDRESS <u>RD 2 Box 175</u>	
3. NAME OF DECEASED (Type or print) First <u>Rosie</u> Middle <u>May</u> Last <u>Cullum</u>		4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1948</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/19/1881</u>
9. AGE (in years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm Henry Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Susie Elizabeth Cullum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>  </u>	
17. INFORMANT <u>Wm H. Cullum, Box 175 Bel Air, Md.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u>			
DUE TO (b) <u>  </u>			
DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) <u>Gerald E Palmer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Type) <u>Burial</u>		22b. DATE THEREOF <u>1/30/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Catholic</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Md.</u>	
23. MORTAL DIRECTOR'S SIGNATURE <u>John G. Ewing, Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>JAN 30 '58</u>		DATE <u>  </u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

JAN 2 1950

RECEIVED  
JAN 2 1950

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00715

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>	
c. LENGTH OF STAY IN Tb <u>1 year</u>		d. STREET ADDRESS <u>666 Green St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>666 Green St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Roland Joseph Dawson</u>		4. DATE OF DEATH <u>January 31</u> 19 <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30</u> 19 <u>57</u>
9. AGE (In years, last birthday) <u>95</u> yrs. <u>11</u> months <u>11</u> days		10. IF UNDER 1 YEAR: Months <u>9</u> Days <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROLAND JOSEPH DAWSON</u>		14. MOTHER'S MAIDEN NAME <u>HELEN MAY DUBREE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>666 Green St.</u>	
17. INFORMANT <u>Roland Dawson</u>		Address <u>Harford Grace Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>71X</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>1</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-31-58</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22a. REC'D BY REGISTRAR <u>Feb 3</u> 58	
22b. NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cem.</u>		22c. LOCATION (City, town, or county) <u>Harford Grace Md.</u>	
22d. DATE THEREOF <u>Feb. 1958</u>		22e. REMOVAL (Specify) <u>Burial</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		24a. ADDRESS <u>Harford Grace Md</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>		24c. DATE <u>FEB 3</u> 58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00716182

1. PLACE OF DEATH a. COUNTY <u>Horton</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Horton</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Dorothy</u> Last <u>Dorsey</u>				4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 28, 1878</u>	9. AGE (in years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>21</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Red Gover</u>				14. MOTHER'S MAIDEN NAME <u>Tellie Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Jettie Stevenson</u> Address <u>270 W. Pines St., York, Pa.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u></u> p. m. <u></u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Lerald C Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Lerald C Palmer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>AMEE Church</u>		22d. LOCATION (City, town, or county) (State) <u>Bella Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ans. Bailey</u>				ADDRESS <u>Darlington Md</u>		24a. REC'D BY REGISTRAR <u></u>	
				24b. REGISTRAR'S SIGNATURE <u></u>		DATE <u>1-7-58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 13 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

00717

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Walters Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>May</u> Last <u>Duke</u>		4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/72</u>
9. AGE (In years last birthday) <u>85</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Harris</u>		14. MOTHER'S MAIDEN NAME <u>Sara McCullough</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs. Ralph Winchester, Port Deposit, Md.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure, terminating</u> <u>+221</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>a chronic decompensated cardio-vascular disease</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I attended the deceased from <u>January 5</u> , 19 <u>58</u> , to <u>January 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>January 7</u> , 19 <u>58</u> , and that death occurred at <u>9:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Forest Hill, Maryland</u> DATE SIGNED <u>January 8, 1958</u>			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.		DATE SIGNED <u>January 8, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>		DATE SIGNED <u>January 8, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Howeell Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leva Patterson</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 10 '58</u>	
ADDRESS <u>Port Deposit, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

EDWARD V. S.

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RECEIVED

## 742 CERTIFICATE OF DEATH

00718

Reg. Dist. No. 150

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Joppa</u>		<u>45 yrs.</u>		TOWN <u>Joppa</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOHN</u> (Middle) <u>FRANCIS</u> (Last) <u>ENNIS</u>				(Month) <u>JAN</u> (Day) <u>29th</u> (Year) <u>1958</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Feb. 7, 1880</u>	<u>77</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Boiler Maintenance</u>		<u>U.S. Govt.</u>		<u>Brooklyn, New York</u>		<u>United States</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Ennis</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>-</u>		<u>Mrs. Mary E. Ennis, Joppa, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>CONGESTIVE HEART FAILURE</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 MOS.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROSIS, GENERALIZED, WITH</u>				MANY YEARS			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>MYOCARDIAL DEGENERATION ON ARTERIOSCLEROTIC BASIS</u>				2 MOS.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CHRONIC BRAIN SYNDROME</u>				2 DAYS			
<u>TERMINAL BILATERAL PAROTID INFECTION</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>2 JAN 58</u>		<u>PROSTATIC HYPERTROPHY (BENIGN)</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>AUG.</u> , 19 <u>51</u> , to <u>JAN.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>29 JAN.</u> , 19 <u>58</u> , and that death occurred at <u>12:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>E. W. Stewart Jr.</u>		M.D. <u>Box 95, EDGEWOOD, MD.</u>		DATE SIGNED <u>1/29/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 1, 1958</u>		<u>Mountain Christian</u>		<u>Joppa, Harford, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
DATE <u>FEB. 1 '58</u>		<u>[Signature]</u>		<u>Howard K. Thompson, Abingdon Md</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED V. A.

13 - 10-3

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00719

Item 9, Film G224, 1/10/58 fcy

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>H 27-50-d</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvred Grace</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				e. STREET ADDRESS <u>723 N Adams St</u>			
3. NAME OF DECEASED (Type or print) <u>Charles Porter EVERETT</u>				4. DATE OF DEATH <u>January 5 1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 11, 1896</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>			
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John N. Everett</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Shewsbury</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Belavi</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>22 SW Head</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>22 SW Head</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with 22 rifle</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>12:15</u> p.m. <u>1-2</u> <u>58</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Harvred Grace</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1-5-58</u>			
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>		22d. LOCATION (City, town, or county) <u>Mumfries, Tenn.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Smith</u> ADDRESS <u>Harford, Md</u>				24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 1 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



5 A 0121

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## CERTIFICATE OF DEATH

Reg. Dist. No.

720

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admision) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase</u>		c. LENGTH OF STAY IN 1b <u>30 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>807 Otsego</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Frank</u> Middle <u>Fernandisco</u> Last <u>?</u>		<b>4. DATE OF DEATH</b> Month <u>1/9/58</u> Day <u>19</u> Year <u>19</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Unknown</u>
<b>9. AGE</b> (In years last birthday) <u>44</u> yrs		<b>10. IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u>	
<b>11. IF UNDER 24 HRS</b> Hours <u>0</u> Min. <u>0</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>B &amp; O Railroad</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Italy</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Unknown</u>	
<b>13. FATHER'S NAME</b> <u>? Fernandez</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Unknown</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>	
<b>17. INFORMANT</b> <u>M. Orlando Angelucci</u>		<b>Address</b> <u>Harford Chase 819 Otsego Dr</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Natural Cardiac Remorhage</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 years</u> <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>Jan 9, 1957</u> , to <u>Jan 9, 1958</u> , that I last saw the deceased alive on <u>Jan 9, 1958</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above <b>ADDRESS</b> (Street, city or town, state) <u>200 North American</u> <b>DATE SIGNED</b> <b>ACTUAL SIGNATURE</b> <u>John Archibald D.</u> M.D. <u>Harford Chase, Maryland</u> <b>PHYSICIAN'S NAME</b> (Type) <u>FRANK WOLBERT MD</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>1/13/58</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Elin</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Harford Chase MD</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Harford Chase, MD</u>		<b>24. REC'D BY REGISTRAR</b> <u>JAN 13 '58</u>	
<b>24b. REGISTRAR'S SIGNATURE</b>			

**OPTIONAL ATTENDING PHYSICIAN.** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

VS A15 (4)  
15M 10/57

BUREAU V. S.

JAN 13 1900

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**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this the bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this the bottom copy may be retained by the funeral director, the third copy of this death certificate assembly should be attached for use as a burial transit permit.

VS A15C 1 55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7 Filed 2-6-58 et

## CERTIFICATE OF DEATH

00721

Reg. Dist. No. 182

743

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Rural Bel Air</u>		<u>5 Years</u>		TOWN <u>Bel Air Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescent Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Mary</u> (First) <u>George</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>January 25</u> <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 7 1886</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Castle, Del.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Peter E. Maran</u>				14. MOTHER'S MAIDEN NAME <u>Laura Foster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>12</u>		17. INFORMANT & ADDRESS <u>Mr Edward Galton</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>Bel Air, Md.</u>		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage, terminating</u>						<u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				(B) <u>Chronic cardio-vascular disease</u>		<u>5 years</u>	
STATING UNDERLYING CAUSE LAST, DUE TO				(C)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1</u> , 19 <u>53</u> , to <u>January 25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>January 24</u> , 19 <u>58</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. H. H. H. H. H.</u> M.D.				DATE SIGNED <u>January 25, 1958</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>Jan 24 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Forest Hill, Md.</u>		LOCATION (City, town, or county) <u>Harford Co., Md.</u>	
24. REC'D BY REGISTRAR <u>Carla Smith</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. D. Bailey</u>		ADDRESS <u>Harford Co., Md.</u>	
DATE <u>JAN 31 '58</u>							

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1000. 2. 4. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838.

721

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                    |  |   |
|--|------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>                    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>  |                                    | c. LENGTH OF STAY IN 1b <u>21 yrs</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>  |                                    | e. STREET ADDRESS <u>111 Bond St</u>   |   |
| 3. NAME OF DECEASED (Type or print) First <u>HARRISON</u> Middle <u>B</u> Last <u>HARRIS</u>   |                                    | 4. DATE OF DEATH <u>Jan 22 1958</u>  |   |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>white</u>      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 3 1898</u>                              |
| 9. AGE (In years last birthday) <u>59 yrs.</u>   |                                    | IF UNDER 1 YEAR: Months <u>59</u> Days <u>22</u> Hours <u>19</u> Min <u>58</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>Forest Hill Md</u>  |                                    | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |   |
| 13. FATHER'S NAME <u>Benjamin Harkins</u>  |                                    | 14. MOTHER'S MAIDEN NAME <u>Emma Jones</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |                                    | 16. SOCIAL SECURITY NO. <u>✓</u>   |   |
| 17. INFORMANT <u>Mrs Blanche M. Harkins Bel Air Md</u>   |                                    | Address <u>111 Bond St</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C-V-D</u><br>DUE TO (c) <u>10 years</u> |                                    |  | INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Kyphosis. Pulmonary Emphysema</u>   |                                    |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. 19 <u>1958</u>   |                                    | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>1949</u> , 19 <u>1958</u> , to <u>1/22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/11/58</u> , 19 <u>58</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.  |                                    |  |   |
| SIGNATURE <u>Robert Barthel</u> M.D.   |                                    | ADDRESS (Street, city or town, state) <u>Forest Hill Md</u> DATE SIGNED <u>1/23/58</u>   |   |
| PHYSICIAN'S NAME (Type) <u>Robert Barthel</u>  |                                    |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>JAN 25-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>   | 22d. LOCATION (City, town, or county) (State) <u>Bel Air Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Martha Lantz Jarrett</u> ADDRESS <u>1000 E. 10th St</u>  |                                    | 24a. RECEIVED BY REGISTRAR <u>Jan 24 1958</u>  | 24b. REGISTRAR'S SIGNATURE <u>W. H. Jones</u>                   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1939

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 152

## 1. PLACE OF DEATH

COUNTY

HARFORD

MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BEL AIR

LENGTH OF STAY (in this place)

70 YRS

HOSPITAL OR INSTITUTION OR STREET ADDRESS

HICKORY, RD #1 Box 181

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

MARYLAND

COUNTY

HARFORD

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

(RURAL) BEL AIR

STREET ADDRESS

(If rural give location)  
HICKORY, RD #1 Box 181

## 3. NAME OF

(First)

(Middle)

(Last)

(Type or Print)

MILLARD

LEO

HARKINS

## 4. DATE

(Month)

(Day)

(Year)

OF DEATH

JAN 1

1958

## 5. SEX

MALE

## 6. COLOR OR RACE

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

WIDOWED

## 8. DATE OF BIRTH

DEC 22, 1887

## 9. AGE last birthday

70 yrs.

## IF UNDER 1 YEAR

Months Days Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FARMER

## 10b. KIND OF BUSINESS OR INDUSTRY

FARMING

## 11. BIRTHPLACE (State or foreign country)

MARYLAND

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

EDWIN HALL HARKINS

## 14. MOTHER'S MAIDEN NAME

ELLA MAHAN

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

212-32-2529

## 17. INFORMANT &amp; ADDRESS (30N)

DONALD HARKINS

(SAME)

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## 1. IMMEDIATE CAUSE (A)

PULMONARY OBSTRUCTION

## 2. ANTECEDENT CAUSE(S) DUE TO

## DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE

## STATING UNDERLYING CAUSE LAST.

BRONCHIOGENIC CARCINOMA

BOTH LUNGS WITH METASTASES

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 18. MEDICAL CERTIFICATION

Bel Air, Md Box 181

## INTERVAL BETWEEN ONSET AND DEATH

1 mos

OVER 1 YR

## 19a. DATE OF OPERATION

AUGUST 28, 57

## 19b. MAJOR FINDINGS OF OPERATION

BRONCHIOGENIC CARCINOMA

## 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

(Year)

(Hour)

21e. INJURY OCCURRED

While at work

Not while at work

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from SEPT 1, 1957, to JAN 1, 1958, that I last saw the deceased alive on DEC 31, 1957, and that death occurred at 7:00 AM, from the causes and on the date stated above.

## SIGNATURE

Philip W. Thompson

M.D.

307 Hickory

## ADDRESS (Street, city, town, state)

Bel Air, Md

## DATE SIGNED

JAN 1, 1958

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

## DATE THEREOF

Jan 4/58

## NAME OF CEMETERY OR CREMATORY

St Ignace

## LOCATION (City, town, or county)

Hickory Harford Md

## 24. REC'D BY REGISTRAR

JAN 3 1958

## REGISTRAR'S SIGNATURE

J. W. H. H. H. H.

## 25. FUNERAL DIRECTOR'S SIGNATURE

Joseph T. Foster

## ADDRESS

Bel Air Md

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in, by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



RECEIVED

JAN 5 1933

BUREAU V. S.

722

## CERTIFICATE OF DEATH

00724

Reg. Dist. No.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Harford</u>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre de Grace</u>                                     |   |
| c. LENGTH OF STAY IN 1b <u>4 hr</u>  |   | d. STREET ADDRESS <u>118 N Stokes St.</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) First <u>Debra</u> Middle <u>Ann</u> Last <u>Hawley</u>  |   | 4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1958</u>   |   |
| 5. SEX <u>female</u>   | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 16, 1957</u>  |
| 9. AGE (In years last birthday) <u>NO</u> yrs.   |   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>24</u> Hours <u></u> Min. <u></u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>US</u>  |   |
| 13. FATHER'S NAME <u>James Stewart Hawley</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Nancy Ann Walker</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |   | 16. SOCIAL SECURITY NO <u></u>  |   |
| 17. INFORMANT <u>James Stewart Hawley - Harre de Grace MD.</u>   |   | Address <u></u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gastroenteritis - dehydration</u><br><u>571.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>19</u> p. m. <u></u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>11/6</u> , 19 <u>58</u> , to <u>1/9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/9</u> , 19 <u>58</u> , and that death occurred at <u>11/9</u> M, from the causes and on the date stated above.  |   |   |   |
| ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.   |   | ADDRESS (Street, city or town, state) <u>Rising Sun, MD</u> DATE SIGNED <u>1/9/58</u>   |   |
| PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr</u>  |   | <u>Rising Sun, MD</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  | 22b. DATE THEREOF <u>Jan 11, 1958</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>  | 22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford Co. MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Madison Mitchell</u>  |   | 24a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u></u>  |   |
| ADDRESS <u>Harre de Grace MD.</u>  |   | DATE <u>JAN 3 '58</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JAN 10 1953

RECEIVED  
JAN 10 1953

745

## CERTIFICATE OF DEATH

Reg. Dist. No.

00725

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> <u>Upper Cross Roads</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)<br>o STATE <u>Maryland</u> b. COUNTY <u>Harford</u>                 |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural-Upper Cross Roads</u>  |  |   |  | c. LENGTH OF STAY IN 1b   |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>none</u>   |  |   |  | e. STREET ADDRESS<br><u>1</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Henry (Harry) Frederick Hess</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>January</u> Day <u>24</u> Year <u>1958</u>   |  |  |   |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Sept 20 1876</u>  |   |
| 9. AGE (In years last birthday)<br><u>81</u> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS<br>Months Days Hours Min.   |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farmer</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Farm</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore city</u>                     |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |  |   |  |   |  |  |   |
| 13. FATHER'S NAME<br><u>George Hess</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Annie Peppier</u>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO.<br><u>215-86-8154</u>   |  | 17. INFORMANT<br><u>Miss A. Everett Hess</u><br>Address                                |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br><u>420.1</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Arteriosclerotic Hypertensive Heart Disease 10 yrs.</u><br>DUE TO<br>(c) <u>Phlebitis, Acute, Right Lower Leg</u> |  |   |  |   |  |  | <u>1 hour</u><br><br><u>2 months</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Hemorrhoids, 3 months</u>   |  |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                 |   |
|   |  |   |  | 20f. (City or town)   |  | (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>September, 1957</u> , to <u>January, 1958</u> , that I last saw the deceased alive on <u>January 23, 1958</u> , and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED                    |  |   |  |   |  |  |   |
| ACTUAL SIGNATURE <u>[Signature]</u> M. D.   |  |   |  |   |  |  |   |
| PHYSICIAN'S NAME (Type) <u>S. JAMES THOMISON, Jr., M. D., Jarrettsville, Maryland</u>   |  |   |  |   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF                         |  | 22c. NAME OF CEMETERY OR CREMATORY  |  | 22d. LOCATION (City, town, or county) (State)  |   |
| <u>Burial</u>   |  | <u>Jan 27 1958</u>                        |  | <u>Goodwill</u>   |  | <u>Rutledge Harford Md.</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>JAN 29 '58</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                       |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00726

723

CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Darlington</u>                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |   |
| c. LENGTH OF STAY IN 1b<br><u>31 hours</u>   |   | d. STREET ADDRESS  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><u>Harford Memorial Hospital</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Baby Girl</u> Middle <u>Hodge</u> Last <u>Hodge</u>   |   | 4. DATE OF DEATH<br>Month <u>Jan</u> Day <u>5</u> Year <u>1958</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <del>SEPARATED</del> | 8. DATE OF BIRTH<br><u>Jan. 4, 1958</u>                       |
| 9. AGE (In years lost birthday) yrs. <u>31</u>   |   | 10. UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>31</u> Days <u>31</u> Hours <u>31</u> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Mo</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Mo</u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Harford Co., Md.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>Page Hodge</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Odessa Harry</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)  |   | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><u>Page Hodge</u>   |   | Address<br><u>Darlington Mo</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prometene &amp; Stenosis</u><br><u>11.0.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>                    </u> DUE TO<br>(c) <u>                    </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u><br>INTERVAL BETWEEN ONSET AND DEATH<br><u>31 hrs</u> |   |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>                    </u> o. m. <u>19</u><br>p. m. <u>                    </u>   | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                          |
| 21. I certify that I attended the deceased from <u>1-4</u> , 19 <u>58</u> , to <u>1-5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-4</u> , 19 <u>58</u> , and that death occurred at <u>11 4</u> M., from the causes and on the date stated above.  |   |  |   |
| ACTUAL SIGNATURE<br><u>[Signature]</u>   |   | DATE SIGNED<br><u>1-5-58</u>   |   |
| PREPARED NAME (Type)<br><u>[Name]</u>  |   | ADDRESS (Street, city or town, state)<br><u>B. A. Hosp. +, Md.</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal Jan. 6 1958</u>  | 22b. DATE THEREOF<br><u>Jan. 6 1958</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Sharta</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>M. C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>H. B. Bailey</u>  |   | 24a. REC'D BY REGISTRAR<br><u>[Signature]</u>  |   |
| ADDRESS<br><u>Darlington</u>   |   | 24b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |

BUREAU V. S.

JAN 8 1938

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

746

CERTIFICATE OF DEATH

Reg. Dist. No. 00737

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Harford</b> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Abingdon</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Abingdon</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |   | d. STREET ADDRESS  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Louis</b> Middle <b>W.</b> Last <b>Hooker</b>   |   | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>13,</b> Year <b>19 58</b>   |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b>          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       | 8. DATE OF BIRTH<br><b>Feb. 12, 1876</b>                                       |
| 9. AGE (In years last birthday) <b>81</b> yrs   |   | IF UNDER 1 YEAR<br>Months <b>13</b> Days <b>13</b> Hours <b>19</b> Min <b>58</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home Construction</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Abingdon, Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Edward G. Hooker</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Horney</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.<br><b>212-12-4758</b>  |  |
| 17. INFORMANT<br><b>Raymond Hooker</b>  |   | Address<br><b>Abingdon, Maryland</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage Jan. 3 '58</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis</b><br>DUE TO<br>(c) |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b><br><b>5 yrs</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>0</b> <b>19</b> p. m.   |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Jan 3</b> , 19 <b>57</b> , to <b>Jan 13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Jan 13</b> , 19 <b>58</b> , and that death occurred at <b>10 A</b> . M., from the causes and on the date stated above  |   |  |  |
| ACTUAL SIGNATURE <b>Fred O Hodous</b>   |   | ADDRESS (Street, city or town, state) DATE SIGNED <b>1-14-58</b>   |  |
| SIGNATURE'S NAME (Type) <b>F.O. Hodous</b>  |   | M.D. <b>Edgewood Md</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  | 22b. DATE THEREOF<br><b>Jan. 16, 1958</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cokesbury Memorial</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Abingdon, Harford, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Howard K. McCombs</b>  |   | ADDRESS<br><b>Abingdon, Md.</b>  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 17 1958</b>                             |
|   |   | 24b. REGISTRAR'S SIGNATURE<br><b>William J. ...</b>  |  |



U. S. A.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00728

## 747 CERTIFICATE OF DEATH

Reg. Dist. No. ....

|   |                                  |  |  |   |  |   |  |
|---|----------------------------------|--|--|---|--|---|--|
| 1. PLACE OF DEATH   |                                  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED   |  |   |  |
| COUNTY <b>Harford</b>   |                                  | MARYLAND   |  | STATE <b>Maryland</b>   |  | COUNTY <b>Harford</b>   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>Rocks</b>   |                                  | LENGTH OF STAY (In this place)<br><b>Life</b>  |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>Rocks R. D.</b> |  |   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                                  |  |  | STREET ADDRESS (If rural give location)   |  |   |  |
| 3. NAME OF DECEASED (First) (Middle) (Last)<br><b>Charles Emerson Iley</b>  |                                  |  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>January 28 19 58</b>                            |  |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, <b>Married</b>  | 8. DATE OF BIRTH<br><b>Feb. 26, 1892</b> | 9. AGE last birthday<br><b>65</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.                       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Foreman Roads</b>   |                                  |  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Rocks Maryland</b>                          |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                   |  |
| 13. FATHER'S NAME<br><b>Warner Elisha Iley</b>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Norris</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)<br><b>Yes</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>213-01-3499</b>  |  | 17. INFORMANT & ADDRESS<br><b>Mrs. Pauline E. Iley Rocks Md.</b>                            |  |   |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                  |  |  | 18. MEDICAL CERTIFICATION   |  |   |  |
| IMMEDIATE CAUSE (A) <b>Cerebral hemorrhage</b>  |                                  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>54 hours</b>   |  |   |  |
| ANTECEDENT CAUSE(S) DUE TO (B) <b>Hypertensive cardio-vascular disease</b>  |                                  |  |  | ?   |  |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)  |                                  |  |  |   |  |   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                                  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |                                  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)  |                                  | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work |  | 21f. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>December 27, 19 57</b> , to <b>January 28, 19 58</b> , that I last saw the deceased alive on <b>January 28, 19 58</b> , and that death occurred at <b>2:05 P.M.</b> from the causes and on the date stated above. |                                  |  |  |   |  |   |  |
| SIGNATURE<br><b>Willard P. Hudson</b>   |                                  |  |  | ADDRESS (Street, city, town, state)<br><b>Forest Hill, Maryland</b>                         |  | DATE SIGNED<br><b>January 29, 1958</b>                          |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                                  | DATE THEREOF<br><b>Jan. 31 1958</b>  |  | NAME OF CEMETERY OR CREMATORY<br><b>William Watters</b>                                     |  | LOCATION (City, town, or county) (State)<br><b>Cooptown Md.</b> |  |
| 24. REC'D BY REGISTRAR<br><b>Jan 31 '58</b>   |                                  | REGISTRAR'S SIGNATURE<br><b>William Watters</b>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles E. Kurtz</b>                                 |  | ADDRESS<br><b>Parrettsville Md.</b>                             |  |

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724

## CERTIFICATE OF DEATH

00729

Reg. Dist. No.

|   |                                  |  |                                      |
|---|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>HARFORD</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>CECIL</b>                 |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HAURE DE GRACE</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>9 DAYS</b>   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>HARFORD MEMORIAL Hosp.</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |
| 3. NAME OF DECEASED<br>(Type or print) <b>SCOTT</b> <b>WINFIELD JACKSON</b>   |                                  | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>21</b> Year <b>1958</b>  |                                      |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-29-1874</b> |
| 9. AGE (In years last birthday) yrs. <b>83</b>  |                                  | 10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Owner, Retired</b>   |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                      |
| 13. FATHER'S NAME<br><b>HENRY JACKSON</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Pennington</b>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)   |                                      |
| 17. INFORMANT<br><b>Richard C. Todd, Bel Air, MD. R F D.2.</b>  |                                  | Address  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Sclerosis</b><br><b>142X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio Renal disease</b><br>DUE TO (c) <b>Sclerosis</b> |                                  |  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |                                      |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that I attended the deceased from <b>1-12</b> , 19 <b>58</b> , to <b>1-21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1-21</b> , 19 <b>58</b> , and that death occurred at <b>4:10</b> M, from the causes and on the date stated above.<br>A. ADDRESS (street, city or town, state) DATE SIGNED                   |                                  |  |                                      |
| ACTUAL SIGNATURE<br><b>A.L. Lewis, M.D.</b>   |                                  | M.D. <b>Harold Grace</b>   |                                      |
| PHYSICIAN'S NAME (Type)   |                                  |  |                                      |
| 22a. BURIAL, CREMATION, REBURY (Type)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>1-23-1958</b>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hopewell Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Port Deposit, Md. Rural</b>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wesley Patterson, Son, Perryville, Md.</b>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 23 '58</b>  |                                      |
| 24b. REGISTRAR'S SIGNATURE<br><b>Wesley Patterson</b>   |                                  |  |                                      |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

NOV 28 1938

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

725

|  |                                 |  |  |
|--|---------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>HARFORD</u> MARYLAND   |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>   |                                 | c. LENGTH OF STAY IN 1b <u>4 days</u> x <u>HAVRE DE GRACE</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEM. HOSPITAL</u>  |                                 | d. STREET ADDRESS <u>RD #1 Post Road</u>   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                 |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Reece</u> Middle <u>Wade</u> Last <u>Jennings</u>   |                                 | 4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1958</u>  |  |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>24 December 25</u>                                     |
| 9. AGE (In years last birthday) <u>32</u> yrs  |                                 | 10. IF UNDER 1 YEAR Months Days Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>  |                                 | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Rue W. Jennings</u>   |                                 | 14. MOTHER'S MAIDEN NAME <u>Nellie Keeton</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                                 | 16. SOCIAL SECURITY NO. <u>357-18-0982</u>   |  |
| 17. INFORMANT Address <u>Post Road</u>   |                                 | 18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC DECOMPENSATION</u><br>340.3 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>X Hypostatic PNEUMONIA</u><br>DUE TO <u>CHRONIC MENINGITIS</u><br>(c) |                                 | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u><br><u>3 days</u><br><u>1 year</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                 |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19   |                                 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>JAN 1</u> , 19 <u>58</u> to <u>JAN 3</u> , 19 <u>58</u> that I last saw the deceased alive on <u>JAN 3</u> , 19 <u>58</u> , and that death occurred at <u>12:45 P.</u> M, from the causes and on the date stated above.   |                                 |  |  |
| ACTUAL SIGNATURE <u>Irvin L. Wachsmann</u> M.D.  |                                 | ADDRESS (Street, city or town, state) <u>Havre de Grace, Md</u> DATE SIGNED <u>1/4/58</u>  |  |
| PHYSICIAN'S NAME (Type) <u>Irvin L. Wachsmann</u> M.D.   |                                 | <u>Havre de Grace, Md.</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>   | 22b. DATE THEREOF <u>1/4/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Oak Ridge Cemetery</u>   | 22d. LOCATION (City, town, or county) (State) <u>Springfield, Illinois</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u> ADDRESS <u>Aberdeen, Md.</u>   |                                 | 24a. REC'D BY REGISTRAR <u>JAN 6 1958</u> 24b. REGISTRAR'S SIGNATURE <u>H. H. Hedrick</u>  |  |

U.S. AIR FORCE

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00731

Reg. Dist. No.

|   |  |                                     |  |  |  |   |  |
|---|--|-------------------------------------|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Harford</b> MARYLAND  |  |                                     |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Havre De Grace</b>   |  |                                     |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓<br><b>Conowingo, R.F.D.</b>   |  |   |  |
| c. LENGTH OF STAY IN 1b<br><b>18 days</b>   |  |                                     |  | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Harford Memorial Hosp. D.O.A.</b>   |  |   |  |
| d. STREET ADDRESS   |  |                                     |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Eva Elaine</b> Middle <b>Johnson</b> Last <b>Johnson</b>  |  |                                     |  | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>11</b> Year <b>19 58</b>   |  |   |  |
| 5. SEX<br><b>F.</b>   |  | 6. COLOR OR RACE<br><b>W.</b>       |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       |  | 8. DATE OF BIRTH<br><b>12-24-57</b>   |  |
| 9. AGE (In years last birthday)<br>yrs. <b>18</b>   |  | IF UNDER 1 YEAR<br>Months <b>18</b> |  | IF UNDER 24 HRS.<br>Hours <b>18</b> Min. <b>58</b>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>  |  |                                     |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Havre Dr. Grace, Md.</b>              |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |                                     |  |  |  |   |  |
| 13. FATHER'S NAME<br><b>Wm. Edward Johnson</b>  |  |                                     |  | 14. MOTHER'S MAIDEN NAME<br><b>Marry Marcell Lowe</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)   |  |                                     |  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  | 17. INFORMANT<br><b>Wm. E. Johnson, Conowingo, Md.</b>                                |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>924.0 Smothered</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>924.0</b><br>(c), stating the underlying cause lost. DUE TO  |  |                                     |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c):  |  |                                     |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                     |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |                                     |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Was sleeping between parents in bed.</b>                                    |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br><b>7</b> o. m. <b>1-11</b> 19 <b>58</b><br>p. m.  |  |                                     |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b> |  |
| 20f. (City or town)<br><b>Conowingo</b>   |  |                                     |  | 20g. (County)<br><b>Cecil</b>  |  | 20h. (State)<br><b>Md.</b>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |                                     |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>R.C. Dodson</b>  |  |                                     |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| NAME (Type)<br><b>R.C. Dodson</b>   |  |                                     |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
|   |  |                                     |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                                     |  | 22b. DATE THEREOF<br><b>1-13-58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Grasspeer - Cem</b>                          |  |
| 22d. LOCATION (City, town, or county)<br><b>Bishop</b>  |  |                                     |  | 22e. (State)<br><b>Virginia</b>  |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Thomas E. McMillon</b>   |  |                                     |  | ADDRESS<br><b>Rising Sun, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>EARL A. '58</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Earl A. '58</b>  |  |                                     |  |  |  |   |  |

TO MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed for the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the funeral home or prior to burial, cremation, or removal.



BUREAU V. B.

1958

RECEIVED

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00732

## 748 CERTIFICATE OF DEATH

Reg. Dist. No. ....

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The burial or cremation copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

|  |                               |   |                                    |  |                 |   |  |
|--|-------------------------------|---|------------------------------------|--|-----------------|---|--|
| 1. PLACE OF DEATH  |                               |   |                                    | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                 |   |  |
| COUNTY <u>Harford</u>  |                               | STATE <u>Maryland</u> COUNTY <u>Harford</u>   |                                    | CITY (If outside corporate limits, write RURAL and give nearest town)  |                 | CITY (If outside corporate limits, write RURAL and give nearest town) |  |
| TOWN <u>Street</u>   |                               | LENGTH OF STAY (In this place) <u>1 yr.</u>   |                                    | TOWN <u>Street</u>   |                 | TOWN <u>Street</u>  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sandy Hook Rd.</u>  |                               |   |                                    | STREET ADDRESS (If rural give location) <u>Sandy Hook Rd.</u>  |                 |   |  |
| 3. NAME OF DECEASED (Type or Print) <u>J. CHARLES</u> (First) (Middle) (Last) <u>LINS</u>  |                               |   |                                    | 4. DATE OF DEATH <u>JAN. 7- 1958</u> (Month) (Day) (Year)  |                 |   |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>   | 8. DATE OF BIRTH <u>11-14-1875</u> | 9. AGE last birthday <u>82</u> yrs.  | IF UNDER 1 YEAR | IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>   |                                    | 11. BIRTHPLACE (State or foreign country) <u>Balto. County, Md.</u>  |                 | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                            |  |
| 13. FATHER'S NAME <u>G. Lins</u>   |                               |   |                                    | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |                 |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT & ADDRESS <u>Charles R. Lins, Sandy Hook Rd., Street, Md.</u>  |                 |   |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                               |   |                                    | 18. MEDICAL CERTIFICATION  |                 |   |  |
| 1. IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>   |                               |   |                                    | INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>   |                 |   |  |
| 2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Hypertensive C-V-D</u>  |                               |   |                                    | pub. 20 yrs.   |                 |   |  |
| 3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u>Nephropgia, Rt.</u>  |                               |   |                                    | 4 yrs.   |                 |   |  |
| 19a. DATE OF OPERATION   |                               | 19b. MAJOR FINDINGS OF OPERATION  |                                    | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                 |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)  |                                    | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)   |                 |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)  |                               | 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/> |                                    | 21f. HOW DID INJURY OCCUR?   |                 |   |  |
| 22. I hereby certify that I attended the deceased from <u>5/27</u> , 19 <u>57</u> , to <u>1/2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/2</u> , 19 <u>58</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. |                               |   |                                    |  |                 |   |  |
| SIGNATURE <u>Robert Barthol</u> M.D.   |                               |   |                                    | DATE SIGNED <u>1/2/58</u>  |                 |   |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |                               | DATE THEREOF <u>1-4-1958</u>  |                                    | NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>   |                 | LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>        |  |
| 24. REC'D BY REGISTRAR <u>1/6/58</u>   |                               | REGISTRAR'S SIGNATURE <u>H. J. Hedrich</u>  |                                    | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co., Inc.</u> ADDRESS <u>4905 York Rd., Balto. 12, Md.</u> |                 |   |  |

3 A 100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

727

## CERTIFICATE OF DEATH

00733

Reg. Dist. No.

|  |  |  |   |  |  |  |   |
|--|--|--|---|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MARYLAND</u>   |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>                       |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Liberty Grove</u>   |  |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/><br><u>Colora, Rural</u>             |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Harmonia Memorial Hospital</u>  |  |  |   | d. STREET ADDRESS  |  |  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |  |  |  |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Lilly Mae M. Guire</u>  |  |  |   | 4. DATE OF DEATH<br>Month Day Year<br><u>January 13, 1958</u>  |  |  |   |
| 5. SEX<br><u>FEMALE</u>  |  | 6. COLOR OR RACE<br><u>WHITE</u>   |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>May 12, 1886</u>                                      |   |
| 9. AGE (In years birth day) <u>71</u> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Domestic Work</u> |   | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                   |   |
| 13. FATHER'S NAME<br><u>James M. Guire</u>   |  |  |   | 14. MOTHER'S MAIDEN NAME<br><u>Emma Stewart</u>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.<br><u>198-26-7483</u>  |   | 17. INFORMANT<br><u>John Barnes</u> Address <u>Harmonia Memorial</u>   |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br><u>331X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>12-12</u> , 19 <u>57</u> , to <u>1-11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-11</u> , 19 <u>58</u> , and that death occurred at <u>5:30</u> M., from the causes and on the date stated above.  |  |  |   |  |  |  |   |
| ACTUAL SIGNATURE<br><u>A.L. Lewis</u>  |  |  |   | ADDRESS (Street, city or town, state) DATE SIGNED<br><u>Harmonia Memorial</u>  |  |  |   |
| PHYSICIAN'S NAME (Type)<br><u>A.L. Lewis, M.D.</u>   |  |  |   |  |  |  |   |
| 22a. BURIAL, CREMATION, OR OTHER DISPOSAL<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>1-15-1958</u>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Harmony Chapel Cem.</u>   |  | 22d. LOCATION (City, town, or county)<br><u>Liberty Grove, Cecil Co. Md.</u> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Deen Peterson</u>   |  |  |   | ADDRESS<br><u>Harmonia Memorial</u>  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>JAN 14 58</u>                             |   |
|  |  |  |   |  |  | 24b. REGISTRAR'S SIGNATURE<br><u>John Barnes</u>                             |   |

BUREAU V. S.

JAN 14 1950

RECEIVED

## 728 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Harford</i> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <i>Md</i> b. COUNTY <i>Harford</i>                      |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>325 Rogers St</i>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <i>Charles</i> First <i>Morgenstern</i> Middle <i>John</i> Last  |  |   |  | 4. DATE OF DEATH <i>1-26-1958</i> Month <i>1</i> Day <i>26</i> Year <i>1958</i>  |  |   |  |
| 5. SEX <i>Male</i>   |  | 6. COLOR OR RACE <i>White</i>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <i>57</i> yrs  |  |
| 9. AGE (In years last birthday) <i>57</i> yrs  |  | IF UNDER 1 YEAR Months <i>5</i> Days <i>1</i> Hours <i>26</i> Min <i>57</i> |  | IF UNDER 24 HRS  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance agent - shoes</i>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <i>Shoe store</i>  |  | 11. BIRTHPLACE (State or foreign country) <i>Czechoslovakia</i>                           |  |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |  |   |  |  |  |   |  |
| 13. FATHER'S NAME <i>Not known</i>   |  |   |  | 14. MOTHER'S MAIDEN NAME <i>Not known</i>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>  |  |   |  | 16. SOCIAL SECURITY NO <i>1-28-58</i>  |  | 17. INFORMANT <i>John C Morgenstern</i> Address <i>Harford</i>                            |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |   |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> DUE TO <i>Coronary atherosclerosis</i> (b) <i>4 days</i> (c) <i>4 days</i>  |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>4 days</i>  |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |
| MEDICAL CERTIFICATION  |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year <i>Jan 26 1958</i> Hour a. m. <i>11</i> p. m. <i>19</i>   |  |   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Churchville</i> |  |
| 20f. (City or town) <i>Churchville</i> (County) <i>Harford</i> (State) <i>Md</i>   |  |   |  |  |  |   |  |
| 21. I certify that I attended the deceased from <i>June 1942</i> to <i>Jan 1958</i> , that I last saw the deceased alive on <i>Jan 26</i> , 1958, and that death occurred at <i>11:46 P.M.</i> from the causes and on the date stated above. |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <i>Ralph Horkey</i> M.D.  |  |   |  | DATE SIGNED <i>Jan 27</i>  |  |   |  |
| PHYSICIAN'S NAME (Type) <i>Ralph Horkey</i>  |  |   |  | <i>Churchville</i>   |  |   |  |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>   |  | 22b. DATE THEREOF <i>1-28-58</i>  |  | 22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Hebrew</i>   |  | 22d. LOCATION (City, town, or county) <i>Balto Md</i> (State) <i>Md</i>                   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc</i> ADDRESS <i>2100 Eutaw Pl</i>  |  |   |  | 24a. REC'D BY REGISTRAR <i>JAN 29 '58</i>  |  | 24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 29 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

749

## CERTIFICATE OF DEATH

00735

Reg. Dist. No.

|   |                                  |   |                                       |
|---|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Harford</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>                   |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Fawn Grove RD, Pa.</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>30yrs.</b>  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  | d. STREET ADDRESS   |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>Fredrick</b> Last <b>Muller</b>  |                                  | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>16,</b> Year <b>19 58</b>  |                                       |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-14, 1892</b> |
| 9. AGE (In years last birthday)<br><b>65 yrs.</b>   |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Merchant</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Gen. Store</b>  |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                       |
| 13. FATHER'S NAME<br><b>Emil Muller</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Alice Duncan</b>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.   |                                       |
| 17. INFORMANT<br><b>Daniel Muller, New Park, Pa.</b>  |                                  | Address   |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage due to chr.</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>hypertension, arteriosclerosis, cardiac</b><br>DUE TO<br>(c) <b>decompensation, cardiac hypertrophy, dropsy</b>                                       |                                  |   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |                                       |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  | INTERVAL BETWEEN ONSET AND DEATH  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. g. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that I attended the deceased from <b>Aug. 30,</b> 19 <b>57,</b> to <b>Jan. 16,</b> 19 <b>58,</b> that I last saw the deceased alive on <b>Jan. 15,</b> 19 <b>58,</b> and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Stewartstown, Pa.</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>Norman H. Gemmill</b> M.D.<br>NAME (Type) <b>Norman H. Gemmill.</b> |                                  |   |                                       |
| 22a. BURIAL, CREMATION, REMOVAL, etc.<br><b>1-20-58</b>   |                                  | 22b. DATE THEREOF   |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Paul Meth. Cem.</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Pylesville, Harford CO., Md.</b>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Kenneth W. Graham</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 21 '58</b>   |                                       |
| ADDRESS<br><b>Stewartstown, Penna.</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Alfred Smith</b>   |                                       |



BUREAU V. S.

14M

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                           |  |  |
|--|---------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Harford</u>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |                           | d. STREET ADDRESS <u>Prospect Hill Farm</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>Ruth</u> First <u>Keeper</u> Middle <u>W</u> Last   |                           | 4. DATE OF DEATH <u>January 31</u> 19 <u>58</u> Month Day Year   |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>Sept 31 1870</u> 87 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>York Co. Penna</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>V. S. A.</u>  |                           | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME <u>Garnet Mc</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Charles Culp</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <u>No</u> (If yes, give dates of service)   |                           | 16. SOCIAL SECURITY NO. <u>No</u>  |  |
| 17. INFORMANT <u>Mrs. Alta Scarborough</u> Address <u>Street</u>   |                           | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u><br><u>40 y. old</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u><br>(c) <u>Due to</u> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                           | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                           | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                           |  |  |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.   |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>  |                           | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
|  |                           | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                           | 22b. DATE THEREOF <u>Feb 2/1958</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Edinburgh Cemetery</u>   |                           | 22d. LOCATION (City, town, or county) (State) <u>York Co. Penna</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> Address <u>Harlington Md</u>  |                           | 24a. REC'D BY REGISTRAR <u>ONE</u> 24b. REGISTRAR'S SIGNATURE <u>ONE</u>   |  |

W. A. GUTHRIE

EST. 1883

W. A. GUTHRIE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

729

## CERTIFICATE OF DEATH

00737

Reg. Dist. No. 185

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>                    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>   |   | d. STREET ADDRESS <u>728 Rock Spring Ave.</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Emily</u> Middle <u>B</u> Last <u>Nelson</u>  |   | 4. DATE OF DEATH<br>Month <u>Jan</u> Day <u>1</u> Year <u>1958</u>   |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-20-79</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |   | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME <u>Robert Garwood</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Margaret Worthington</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO <u>None</u>   |   |
| 17. INFORMANT <u>Mrs L.W. Shinnick, 728 Rock Spring Ave., Bel Air, Md.</u>  |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Insufficiency Post-op</u><br><u>5721</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforated diverticula of sigmoid with pelvic abscess</u><br>DUE TO (c) <u>Sigmoid with pelvic abscess</u> |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>12-30-57</u> to <u>1-1-58</u> , that I last saw the deceased alive on <u>1-1-58</u> , and that death occurred at <u>6:17 P.M.</u> , from the causes and on the date stated above.  |   |  |   |
| ACTUAL SIGNATURE <u>Wm. K. Brendle</u> M.D.   |   | ADDRESS (Street, city or town, state) <u>Harford, Md</u> DATE SIGNED <u>1-1-58</u>   |   |
| PHYSICIAN'S NAME (Type) <u>Wm. K. Brendle, M.D.</u>   |   |  |   |
| 22a. BURIAL, CREMATION, or other (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>1-4-1958</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Springs Cem.</u>  | 22d. LOCATION (City, town, or county) (State) <u>Forrest Hill, Md.</u>              |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson</u> ADDRESS <u>Perryville, Md.</u>   |   | 24a. REC'D BY REGISTRAR <u>Jan 3 1958</u>  | 24b. REGISTRAR'S SIGNATURE <u>U. H. H. H.</u>                                       |

BUREAU V. S.

JAN 3 1953

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

730

## CERTIFICATE OF DEATH

Reg. Dist. No.

00738

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Harford</b> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>41 E. Bel Air Avenue</b>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3 NAME OF DECEASED (Type or print) <b>Silver Mitchell Osborn</b>  |   | 4. DATE OF DEATH <b>January 30 1958</b>  |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>25 Oct. 1880</b>   |
| 9. AGE (In years last birthday) <b>77</b> yrs   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Banker &amp; Canner</b>                                    |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>Charles B. Osborn</b>  |   | 14. MOTHER'S MAIDEN NAME <b>J. Gertrude Mitchell</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>   |   | 16. SOCIAL SECURITY NO. <b>217-07-7457</b>   |  |
| 17. INFORMANT <b>Gertrude Umbarger</b>  |   | Address <b>41 E. Bel Air Aberdeen, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalize Cancer</b><br>177x DUE TO <b>Cancer of prostate</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancer of prostate</b><br>DUE TO (c) |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>3 7/8 yrs</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>December 15, 1957</b> , to <b>January 30, 1958</b> , that I last saw the deceased alive on <b>January 28, 1958</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above.   |   |  |  |
| ACTUAL SIGNATURE <b>Andre Weiss</b> M.D.  |   | ADDRESS (Street, city or town, state) <b>17 N. Phila. Blvd.</b> DATE SIGNED  |  |
| PHYSICIAN'S NAME (Type) <b>Andre Weiss</b> M.D.   |   | <b>Aberdeen, Md.</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 22b. DATE THEREOF <b>2/2/58</b>   | 22c. NAME OF CEMETERY OR CREMATORY <b>Grove Cemetery</b>   | 22d. LOCATION (City, town, or county) (State) <b>Aberdeen, Md.</b>                             |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Durring</b> ADDRESS <b>Aberdeen, Maryland</b>   |   | 24a. REC'D BY REGISTRAR <b>Feb 4 '58</b>   | 24b. REGISTRAR'S SIGNATURE <b>John G. Durring</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

1873

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

751

## CERTIFICATE OF DEATH

00739

Reg. Dist. No.

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Lewis</u> Last <u>Pirion</u>   |  | 4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1958</u>  |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>Colored</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/28/1857</u>                                     |
| 9. AGE (In years last birthday) <u>100</u> yrs.  |  | 10. IF UNDER 1 YEAR Months Days Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Lewis Pirion</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Harriette Stansbury</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <u>None</u>  |  |
| 17. INFORMANT <u>Geo. H. Pirion</u> Address <u>Perryman Md.</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Senility</u><br>DUE TO <u>794X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u><br>DUE TO (c) <u></u> |  |  | INTERVAL BETWEEN ONSET AND DEATH                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>19</u> p. m. <u></u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                   |
| 21. I certify that I attended the deceased from <u>7/28</u> , 19 <u>56</u> , to <u>1/6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/3</u> , 19 <u>58</u> , and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above.                                   |  |  |  |
| ACTUAL SIGNATURE <u>George T. Stansbury</u>  |  | ADDRESS (Street, city or town, state) <u>M.D. 564 Revolution St. Harford, Md.</u>  |  |
| PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>   |  | DATE SIGNED <u>11/7/58</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF <u>1/8/1958</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Union M. E.</u>  | 22d. LOCATION (City, town, or county) (State) <u>Aberdeen P.V. Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Carriag</u> ADDRESS <u>Aberdeen Md.</u>  |  | 24a. REC'D BY REGISTRAR <u>JAN 8 '58</u>   | 24b. REGISTRAR'S SIGNATURE <u>W. J. Carriag</u>                        |



RECEIVED  
JAN 8 1953  
BUREAU V. S.

752

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                 |  |   |
|--|---------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND   |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen #1</u>  |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural #1</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bush Chapel Rd.</u>  |                                 | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <u>Rechel Eaylor Pizion</u>  |                                 | 4. DATE OF DEATH <u>1</u> <u>19</u> <u>1958</u>  |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/18/1887</u>             |
| 9. AGE (In years last birthday) <u>70</u> yrs.   |                                 | 10. IF UNDER 1 YEAR IF UNDER 24 HRS  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |                                 | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>Bonnie Smith</u>  |                                 | 14. MOTHER'S MAIDEN NAME <u>Eliza Taylor</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u>   |                                 | 16. SOCIAL SECURITY NO <u>—</u>  |   |
| 17. INFORMANT <u>Harmond Pizion Aberdeen #1 Md.</u>  |                                 | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br><u>443X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive Arteriosclerotic Heart Disease</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> |                                 |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                 |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u>   |                                 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>11/16</u> , 19 <u>56</u> , to <u>1/19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/19</u> , 19 <u>58</u> , and that death occurred at <u>10:00 A</u> M, from the causes and on the date stated above.  |                                 |  |   |
| ACTUAL SIGNATURE <u>George J. Stansbury</u> M.D.   |                                 | ADDRESS (Street, city or town, state) <u>569 Revolution St., Hagerstown, Md.</u>   |   |
| DATE SIGNED <u>1/21/58</u>   |                                 |  |   |
| PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>   |                                 |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF               | 22c. NAME OF CEMETERY OR CREMATORY   | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u>  | <u>1/22/58</u>                  | <u>Union Mt. E.</u>  | <u>Aberdeen Maryland</u>                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Carrying Aberdeen Md.</u>  |                                 | ADDRESS  |   |
| 24a. REC'D BY REGISTRAR  |                                 | 24b. REGISTRAR'S SIGNATURE   |   |
| DATE <u>JAN 22 '58</u>   |                                 | <u>Aberdeen</u>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 18 1950

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

753

## CERTIFICATE OF DEATH

00741

Reg. Dist. No.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND   |   |   | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Harford Grace Rural</u>   |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Harford Grace Rural</u>                           |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>#1 - Robin Hood Road</u>  |   |   | e. STREET ADDRESS<br><u>#1 - Robin Hood Road</u>   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Irvin</u> Middle <u>Henry</u> Last <u>Preston</u>  |   |   | 4. DATE OF DEATH<br>Month <u>Jan</u> Day <u>23rd</u> Year <u>1958</u>  |  |  |
| 5. SEX<br><u>male</u>  | 6. COLOR OR RACE<br><u>white</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9/7/1884</u>  |  | 9. AGE (In years last birthday)<br><u>73</u> yrs.                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Carrier Farmer</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |   | 13. FATHER'S NAME<br><u>Alexander Preston</u>  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Alice Slay</u>  |   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><u>No</u>   |  |  |
| 16. SOCIAL SECURITY NO.<br><u>213-10-7008</u>  |   |   | 17. INFORMANT<br>Address<br><u>Wife Harford Grace #1 Road</u>  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br><u>4.00.0</u> DUE TO (b) <u>arteriosclerotic heart disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1958</u> |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1958</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>19</u> p. m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)  | (County)   | (State)  |
| 21. I certify that I attended the deceased from <u>1/23/1958</u> to <u>1/23/1958</u> that I last saw the deceased alive on <u>1/23/1958</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.   |   |   |  |  |  |
| ACTUAL SIGNATURE <u>Dr. L. H. Adams</u> M.D.   |   |   | ADDRESS (Street, city or town, state) <u>407 S. Lincoln St. Harford</u>  |  |  |
| DATE SIGNED <u>1/23/58</u>   |   |   | DATE SIGNED <u>1/23/58</u>   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |   | 22b. DATE THEREOF<br><u>1/26/1958</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Wesley Chapel</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Aberdeen Ry - Maryland</u>         |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John G. Harring</u>   |   |   | ADDRESS<br><u>Aberdeen Md.</u>   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>JAN 28 58</u>                                       |
| 24b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AN 2 1958

RECEIVED

731

## CERTIFICATE OF DEATH

Reg. Dist. No.

U4742  
152

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Harford</u>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |  | d. STREET ADDRESS   |   |
| 3. NAME OF DECEASED (Type or print) <u>Wm. L. Reynolds</u> First <u>L</u> Middle <u>Reynolds</u> Last  |  | 4. DATE OF DEATH <u>Jan 2</u> Month <u>Jan</u> Day <u>2</u> Year <u>1958</u>  |   |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 2 1863</u>                                    |
| 9. AGE (In years and birthday) <u>94</u> yrs   |  | IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Carpenter</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co Md</u>  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>                             |
| 13. FATHER'S NAME <u>Lewis K Reynolds</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Shanahan Schiteloch</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  | 16. SOCIAL SECURITY NO. <u>No</u>   |   |
| 17. INFORMANT <u>Mrs Harriet Bowman</u>  |  | Address <u>  </u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY—<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br><u>932 X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u><br>DUE TO (c) <u>  </u> |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u><br><u>5-10 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19 <u>  </u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                  |
| 21. I certify that I attended the deceased from <u>JAN 5</u> , 19 <u>57</u> , to <u>2 JAN</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>30 Dec</u> , 19 <u>57</u> , and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above.  |  |   |   |
| ACTUAL SIGNATURE <u>Charles Richardson</u> M.D.  |  | ADDRESS (Street, city or town, state) <u>126 S. Main St. Bel Air, Md</u> DATE SIGNED <u>1/6/58</u>  |   |
| PHYSICIAN'S NAME (Type) <u>Charles Richardson</u>  |  | <u>126 S. Main St., Bel Air, Md.</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF  | 22c. NAME OF CEMETERY OR CREMATORY  | 22d. LOCATION (City, town, or county) (State)                         |
| <u>Burial</u>  | <u>Jan 5, 1958</u>   | <u>Trinity Cn</u>   | <u>Harford Co Md</u>  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>   |  | ADDRESS <u>Harford Md</u>   |   |
| 24a. REC'D BY REGISTRAR <u>Jan 3, 1958</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>H. S. Bailey</u>  |   |

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The burial or cremation copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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## CERTIFICATE OF DEATH

Item 1, Film 2221 1-23-58 et

Reg. Dist. No. ....

|  |                           |  |                                    |  |                 |   |                  |
|--|---------------------------|--|------------------------------------|--|-----------------|---|------------------|
| 1. PLACE OF DEATH  |                           |  |                                    | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                 |   |                  |
| COUNTY <u>HARTFORD</u>   |                           | MARYLAND   |                                    | STATE <u>MD</u>  |                 | COUNTY <u>HARTFORD</u>  |                  |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>  |                           | LENGTH OF STAY (in this place)   |                                    | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> |                 | 18 years  |                  |
| TOWN <u>ARMY Chemical Center of Md</u>   |                           |  |                                    | TOWN <u>Bel Air</u>  |                 |   |                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                           |  |                                    | STREET ADDRESS (If rural give location) <u>Wakely Terrace</u>                        |                 |   |                  |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ANTON WARD SEGRAVES</u>   |                           |  |                                    | 4. DATE OF DEATH (Month) (Day) (Year) <u>January 20, 19 58</u>                       |                 |   |                  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>   | 8. DATE OF BIRTH <u>May 6/1899</u> | 9. AGE last birthday <u>58</u> yrs.  | IF UNDER 1 YEAR |   | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DIAMOND ALKAL</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>CORP. TAKER</u>   |                                    | 11. BIRTHPLACE (State or foreign country) <u>Grassay Creek NC.</u>                   |                 | 12. CITIZEN OF WHAT COUNTRY? <u>US</u>                                |                  |
| 13. FATHER'S NAME <u>C D Segraves</u>  |                           |  |                                    | 14. MOTHER'S MAIDEN NAME <u>Lillian Blivins</u>                                      |                 |   |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)  |                           | 16. SOCIAL SECURITY NO. <u>2-10-14 440-1</u>   |                                    | 17. INFORMANT & ADDRESS <u>JAMES E SEGRAVES Baltimore 1515 GREENVIEW RD MD</u>       |                 |   |                  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                           |  |                                    | 18. MEDICAL CERTIFICATION  |                 | INTERVAL BETWEEN ONSET AND DEATH                                      |                  |
| IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>   |                           |  |                                    |  |                 | <u>3 minute</u>   |                  |
| ANTECEDENT CAUSE(S) DUE TO   |                           |  |                                    |  |                 |   |                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE   |                           |  |                                    |  |                 |   |                  |
| STATING UNDERLYING CAUSE LAST, DUE TO  |                           |  |                                    |  |                 |   |                  |
| (C)  |                           |  |                                    |  |                 |   |                  |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                           |  |                                    |  |                 |   |                  |
| 19a. DATE OF OPERATION   |                           | 19b. MAJOR FINDINGS OF OPERATION   |                                    |  |                 | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |                                    | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                         |                 |   |                  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)  |                           | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                                    | 21f. HOW DID INJURY OCCUR?   |                 |   |                  |
| 22. I hereby certify that I attended the deceased from ..... 19 <u>52</u> to <u>Jan 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 20</u> , 19 <u>58</u> , and that death occurred at <u>3 P.</u> M. from the causes and on the date stated above. |                           |  |                                    |  |                 |   |                  |
| SIGNATURE <u>Charles Richardson</u>  |                           |  |                                    | ADDRESS (Street, city, town, state) <u>Bel Air, Md.</u>                              |                 | DATE SIGNED <u>1/14/58</u>  |                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>   |                           | DATE THEREOF <u>Jan 16/58</u>  |                                    | NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial</u>                                |                 | LOCATION (City, town, or county) (State) <u>Bel Air Hartford MD</u>   |                  |
| 24. REC'D BY REGISTRAR   |                           | REGISTRAR'S SIGNATURE <u>John W. Fater</u>   |                                    | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Fater</u>                                |                 | ADDRESS <u>Bel Air, Maryland</u>                                      |                  |
| DATE <u>JAN 15 1958</u>  |                           |  |                                    |  |                 |   |                  |



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18   |  |                                       |  |   |  |  |  |   |                              |   |  |
|---|--|---------------------------------------|--|---|--|--|--|---|------------------------------|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                                       |  |   |  |  |  |   |                              |   |  |
| Reg. Dist. No. 10744  |  |                                       |  |   |  |  |  |   |                              |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND  |  |                                       |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Harford</u> |  |   |                              |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Parlinton</u>  |  |                                       |  | c. LENGTH OF STAY IN 1b<br><u>Lifetime</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Parlinton</u>                                 |  |   |                              | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Rt#1 Box 66</u>  |  |                                       |  |   |  | d. STREET ADDRESS<br><u>Rt#1 Box 66</u>  |  |   |                              |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Daniel</u> Middle <u>L.</u> Last <u>Smith</u>   |  |                                       |  |   |  | 4. DATE OF DEATH<br>Month <u>January</u> Day <u>8</u> Year <u>1958</u>   |  |   |                              |   |  |
| 5. SEX<br><u>M</u>  |  | 6. COLOR OR RACE<br><u>C</u>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>3-7-1920</u>  |  | 9. AGE (in years last birthday)<br><u>37</u> yrs.                     |                              | 10. IF UNDER YEAR<br>Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>                       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Cook's Helper</u>   |  |                                       |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>V.A. Hospital</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Parlinton, Md.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. C.</u>                       |                              |   |  |
| 13. FATHER'S NAME<br><u>Warren Presberry</u>  |  |                                       |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Dorothy C. Smith</u>  |  |   |                              |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>yes</u> (If yes, give war or dates of service)<br><u>WW II</u>   |  |                                       |  | 16. SOCIAL SECURITY NO.<br><u>220-05-1274</u>   |  | 17. INFORMANT<br><u>Mrs. Catharine Smith, Parlinton, Md.</u><br>Address <u>Rt#1 Box 66</u>   |  |   |                              |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br><u>932.9</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Exposure to cold</u><br>DUE TO (c) <u></u>  |  |                                       |  |   |  |  |  |   |                              |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>1 Pk. Wt. 110 lbs</u>   |  |                                       |  |   |  |  |  |   |                              |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>   |  |                                       |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Spent hours out in snow, improperly clothed</u>          |  |  |  |   |                              |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>19</u> p. m. <u></u>   |  |                                       |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u></u>  |  | 20f. (City or town)<br><u></u> (County)<br><u></u> (State)<br><u></u> |                              |   |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |                                       |  |   |  |  |  |   |                              |   |  |
| ACTUAL SIGNATURE <u>Gerard C Palmer</u> M.D.  |  |                                       |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u>   |  |   | DATE SIGNED<br><u>1-8-58</u> |   |  |
| EXAMINER'S NAME (Type) <u>Gerard C Palmer, M.D.</u>   |  |                                       |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>md</u>  |  |   |                              |   |  |
|   |  |                                       |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |                              |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>1-11-1958</u> |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Assanna Methodist Cem.</u>   |  |  |  | 22d. LOCATION (City, town, or county)<br><u>Parlinton</u>             |                              | (State)<br><u>md</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Atkins &amp; Bullard, Shore de Grace, Md</u>   |  |                                       |  |   |  | ADDRESS <u>556 Lewis St</u>  |  | 24a. REC'D BY REGISTRAR<br><u></u>                                    |                              | 24b. REGISTRAR'S SIGNATURE<br><u></u>   |  |
| DATE <u>JAN 1 &amp; '58</u>   |  |                                       |  |   |  |  |  |   |                              |   |  |

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RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 756 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **110745**

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>427-507-d</b> <span style="float: right;">MARYLAND</span>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MD</b> b. COUNTY <b>Harpur</b>                         |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Edgewood</b>  |  |  |  | c. LENGTH OF STAY IN TB  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Toppa</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>D.O.A. Dr. H. H. H. Office</b>  |  |  |  | d. STREET ADDRESS  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>Hythern</b> First <b>Thomas</b> Middle <b>Thom</b> Last <b>5</b>  |  |  |  | <b>4. DATE OF DEATH</b> <b>January 16</b> Month <b>1958</b> Year   |  |   |  |
| <b>5. SEX</b><br><b>F</b>  |  | <b>6. COLOR OR RACE</b><br><b>C</b>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><b>May, 15, 1894</b>   |  |
| <b>9. AGE</b> (In years last birthday)<br><b>63</b> yrs.   |  | <b>10. UNDER 1 YEAR</b><br>Months <b>0</b> Days <b>0</b>   |  | <b>11. UNDER 24 HRS.</b><br>Hours <b>0</b> Min. <b>0</b>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Servant</b>   |  |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Domestic</b>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Virginia</b>                               |  |
| <b>13. FATHER'S NAME</b><br><b>Sheppard Thomas</b>   |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Unknown</b>  |  |   |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unknown)<br><b>no</b>  |  | <b>16. SOCIAL SECURITY NO.</b><br><b>012-18-8602</b>   |  | <b>17. INFORMANT</b> <b>Marie Davis</b> Address <b>17 Clifton Pl., Brooklyn, N.Y.</b>  |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><b>PART I. DEATH WAS CAUSED BY:</b><br><b>IMMEDIATE CAUSE (a) Coronary occlusion</b><br><b>4.20.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>   |  |  |  |  |  |   |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>   |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)   |  |
| <b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> |  |  |  |  |  |   |  |
| <b>ACTUAL SIGNATURE</b> <b>Gerald E Palmer</b> M.D.  |  |  |  | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>Bel Air, Md</b>  |  |   |  |
| <b>EXAMINER'S NAME (Type)</b> <b>Gerald E Palmer MD</b>  |  |  |  | <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>                                      |  |   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b>   |  | <b>22b. DATE THEREOF</b><br><b>Jan. 18, 1958</b>   |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Community, Baptist</b>   |  | <b>22d. LOCATION</b> (City, town, or county) (State)<br><b>Toppa, Harford, Maryland</b>           |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Howard E. H. H. H.</b> ADDRESS <b>Abingdon, Maryland.</b>  |  |  |  | <b>24a. REC'D BY REGISTRAR</b><br><b>DATE</b> <b>JAN 20 '58</b>  |  | <b>24b. REGISTRAR'S SIGNATURE</b>   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WILSON V. S.

1938

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

732

CERTIFICATE OF DEATH

Reg. Dist. No.

00746

|  |                                  |  |  |  |  |  |  |
|--|----------------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>HARFORD</b> MARYLAND   |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HAVRE DE GRACE</b>  |                                  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HAVRE DE GRACE</b>                                  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>HARFORD MEMORIAL Hosp.</b>  |                                  |  |  | d. STREET ADDRESS<br><b>802 LAFAYETTE</b>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>TRABUE</b>  |                                  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>JANUARY 7 1958</b>  |  |  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1/6/58</b>  |  | 9. AGE (In years last birthday) yrs. Months Days Hours Min.<br><b>5</b>    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>   |                                  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>               |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>HARRY LEWIS TRABUE</b>   |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>IRENE ISON</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO   |  | 17. INFORMANT Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary atelectasis</b><br><b>7625</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b><br>DUE TO (c) |                                  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 Hours</b><br><b>1 day</b>                            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)     |  |
|  |                                  |  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I attended the deceased from <b>1/6/58</b> , to <b>1/7/58</b> , that I last saw the deceased alive on <b>1/7/58</b> , and that death occurred at <b>4:12 P.M.</b> , from the causes and on the date stated above.   |                                  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Dr. W. W. W. W.</b>   |                                  |  |  | ADDRESS (Street, city or town, state)<br><b>Havre de Grace, Md</b>   |  |  |  |
| DATE SIGNED<br><b>1/8/58</b>   |                                  |  |  |  |  |  |  |
| PHYSICIAN'S NAME (Type)  |                                  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | 22b. DATE THEREOF<br><b>1-7-58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>HARFORD MEMORIAL HOSPITAL</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>HAVRE DE GRACE, MD</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Harry R. Zully Administrator</b>  |                                  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 15 1958</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Ch. J. J.</b>                             |  |

2071211

BUREAU V. S.

NOV 19 1964

RECEIVED

Reg. Dist. No. 00747

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                               |  |                                      |  |  |
|--|-------------------------------|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harpard</u>  |                               | MARYLAND   |                                      | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Harpard</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrods Grace</u>  |                               | c. LENGTH OF STAY IN 1b <u>10 DAYS</u>   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrods Grace</u>                                    |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Larkland Memorial Hospital</u>   |                               |  |                                      | d. STREET ADDRESS <u>556 Warren Street</u>   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>EDWARD</u> Last <u>Vessey</u>   |                               | 4. DATE OF DEATH JAN. 14   |                                      | Day Year 1958  |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <u>JAN. 14 1883</u> | 9. AGE (In years last birthday) <u>75</u> yrs  | IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>   |                                      | 11. BIRTHPLACE (State or foreign country) <u>DEL.</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                               | 13. FATHER'S NAME <u>William Vessey</u>  |                                      | 14. MOTHER'S MAIDEN NAME <u>Mary ?</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                               | 16. SOCIAL SECURITY NO. _____  |                                      | 17. INFORMANT Address <u>Mrs. Pearl L. Thompson Harrods Grace Mo.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO <u>Caused by Myocarditis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Chronic Osseous Refracts</u><br>DUE TO (b) _____<br>(c) _____ |                               | INTERVAL BETWEEN ONSET AND DEATH   |                                      |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                      |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |                                      |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>Jan 14 1958</u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20f. (City or town) (County) (State)   |                               |  |                                      |  |  |
| 21. I certify that I attended the deceased from <u>Jan 14 1958</u> to <u>Jan 14 1958</u> that I last saw the deceased alive on <u>Jan 14 1958</u> and that death occurred at <u>10:27</u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><u>R. L. Lewis MD</u> <u>Harrods Grace Md.</u>                    |                               |  |                                      |  |  |
| ACTUAL SIGNATURE   |                               | PHYSICIAN'S NAME (Type)  |                                      |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                               | 22b. DATE THEREOF <u>JAN 1958</u>  |                                      | 22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u>   |  |
| 22d. LOCATION (City, town, or county) <u>HARRODS GRACE MO.</u>   |                               | (State)  |                                      |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>  |                               | ADDRESS <u>Harrods Grace, Md.</u>  |                                      | 24a. REC'D BY REGISTRAR DATE <u>JAN 20 '58</u>   |  |
| 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |                               |  |                                      |  |  |



BUREAU V. S.

AN 1958

**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00748

734 CERTIFICATE OF DEATH

Reg. Dist. No. ....

|   |                                  |   |   |  |                                    |   |                                    |
|---|----------------------------------|---|---|--|------------------------------------|---|------------------------------------|
| <b>1. PLACE OF DEATH</b>  |                                  |   |   | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>   |                                    |   |                                    |
| COUNTY <u>HARFORD</u>   |                                  | STATE <u>MD</u> COUNTY <u>HARFORD</u>   |   | CITY (If outside corporate limits, write RURAL and give nearest town) <u>DEL AIR</u>             |                                    | CITY (If outside corporate limits, write RURAL and give nearest town) <u>DEL AIR MD</u> |                                    |
| OR TOWN <u>DEL AIR</u>  |                                  | LENGTH OF STAY (in this place) <u>2 months</u>  |   | STREET ADDRESS   |                                    | (If rural give location)  |                                    |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>306 Thomas St.</u>   |                                  |   |   |  |                                    |   |                                    |
| <b>3. NAME OF DECEASED</b> (First) <u>GEORGE</u> (Middle) <u>LEON</u> (Last) <u>WALKER</u>  |                                  |   |   | <b>4. DATE OF DEATH</b> (Month) <u>JANUARY</u> (Day) <u>13</u> (Year) <u>1958</u>                |                                    |   |                                    |
| <b>5. SEX</b> <u>M</u>  | <b>6. COLOR OR RACE</b> <u>W</u> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED.</b> (Specify) <u>Single</u>   | <b>8. DATE OF BIRTH</b> <u>July 21-1900</u> | <b>9. AGE last birthday</b> <u>57</u> yrs.   | <b>IF UNDER 1 YEAR</b> Months Days |   | <b>IF UNDER 24 HRS.</b> Hours Min. |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Doctor</u>  |                                  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |   | <b>11. BIRTHPLACE</b> (State or foreign country) <u>Wilmington Del</u>                           |                                    | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>US</u>   |                                    |
| <b>13. FATHER'S NAME</b> <u>Geo B Walker</u>  |                                  |   |   | <b>14. MOTHER'S MAIDEN NAME</b> <u>Annie McBERTY</u>   |                                    |   |                                    |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>World War II</u>  |                                  | <b>16. SOCIAL SECURITY NO.</b>  |   | <b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs Mary W. Haysmeyer 3301 Capital Road Wilmington Del</u> |                                    |   |                                    |
| <b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  |                                  |   |   | <b>18. MEDICAL CERTIFICATION</b>   |                                    |   |                                    |
| <b>IMMEDIATE CAUSE</b> (A) <u>Acute PULMONARY EDEMA</u>   |                                  |   |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 hrs.</u>  |                                    |   |                                    |
| <b>ANTECEDENT CAUSE(S)</b> DUE TO (B) <u>CARDIAC FAILURE</u>  |                                  |   |   | <u>2 or 3 days</u>   |                                    |   |                                    |
| <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> DUE TO (C) <u>BRONCHOPNEUMONIA and</u>  |                                  |   |   | <u>2 or 3 days</u>   |                                    |   |                                    |
| <b>STATING UNDERLYING CAUSE LAST.</b> <u>Arteriosclerotic CARDIOVASCULAR DISEASE</u>  |                                  |   |   | <u>UNDETERMINED</u>  |                                    |   |                                    |
| <b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>CHRONIC ALCOHOLISM</u>   |                                  |   |   | <u>over 7 years</u>  |                                    |   |                                    |
| <b>19a. DATE OF OPERATION</b>   |                                  | <b>19b. MAJOR FINDINGS OF OPERATION</b>   |   | <b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>                     |                                    |   |                                    |
| <b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>   |                                  | <b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |   | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)                              |                                    |   |                                    |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>  |                                  | <b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | <b>21f. HOW DID INJURY OCCUR?</b>  |                                    |   |                                    |
| <b>22. I hereby certify that I attended the deceased from</b> <u>JAN 11</u> , 19 <u>58</u> , to <u>JAN 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JAN 12</u> , 19 <u>58</u> , and that death occurred at <u>11:50</u> AM, from the causes and on the date stated above. |                                  |   |   |  |                                    |   |                                    |
| <b>SIGNATURE</b> <u>Paul S. Stonerick Jr.</u>   |                                  |   |   | <b>ADDRESS</b> (Street, city, town, state) <u>M.D. 115 FULFORD AVE. BEL AIR MD.</u>              |                                    |   |                                    |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>   |                                  |   |   | <b>DATE SIGNED</b> <u>1/13/58</u>  |                                    |   |                                    |
| <b>DATE THEREOF</b> <u>Jan 16 1958</u>  |                                  | <b>NAME OF CEMETERY OR CREMATORY</b> <u>Cathedral Cemetery</u>  |   | <b>LOCATION</b> (City, town, or county) <u>Wilmington Del</u>                                    |                                    | (State)   |                                    |
| <b>24. REC'D BY REGISTRAR</b>   |                                  | <b>REGISTRAR'S SIGNATURE</b> <u>Ell. Leach</u>  |   | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph J. Foster</u>                                  |                                    | <b>ADDRESS</b> <u>Bel Air Md</u>  |                                    |
| <b>DATE</b> <u>JAN 15 '58</u>   |                                  |   |   |  |                                    |   |                                    |

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RECEIVED

## 757 CERTIFICATE OF DEATH

Reg. Dist. No. ....

|   |                              |  |  |  |                                |   |                                |
|---|------------------------------|--|--|--|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH   |                              |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                                |   |                                |
| COUNTY <u>Hartford</u>  |                              | MARYLAND   |  | STATE <u>Md.</u>   |                                | COUNTY <u>Hartford</u>  |                                |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Forest Hill</u>  |                              | LENGTH OF STAY (in this place)<br><u>46 yrs</u>  |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Forest Hill</u> |                                |   |                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                              |  |  | STREET ADDRESS (If rural give location)  |                                |   |                                |
| 3. NAME OF DECEASED (Type or Print)   |                              |  |  | 4. DATE OF DEATH   |                                |   |                                |
| (First) <u>Roland</u> (Middle) (Last) <u>Ward</u>   |                              |  |  | (Month) (Day) (Year)<br><u>JAN 17, 1958</u>  |                                |   |                                |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>MARRIED</u>   | 8. DATE OF BIRTH<br><u>JUNE 16, 1882</u> | 9. AGE last birthday<br><u>75</u> yrs.   | IF UNDER 1 YEAR<br>Months Days |   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FARMER</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Farm</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Chestnut Hill, Harf. Co., Md.</u>                |                                | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |                                |
| 13. FATHER'S NAME<br><u>JAMES A. WARD</u>   |                              |  |  | 14. MOTHER'S MAIDEN NAME<br><u>JENNIE McLaughlin</u>   |                                |   |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)<br><u>NO</u>  |                              | 16. SOCIAL SECURITY NO.<br><u>213-38-6274</u>  |  | 17. INFORMANT & ADDRESS<br><u>Mrs. Roland Ward Forest Hill, Md.</u>                              |                                |   |                                |
| 18. MEDICAL CERTIFICATION   |                              |  |  |  |                                | INTERVAL BETWEEN ONSET AND DEATH  |                                |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                              |  |  |  |                                |   |                                |
| IMMEDIATE CAUSE (A) <u>CARDIO-RESPIRATORY FAILURE</u>   |                              |  |  |  |                                | <u>12 HOURS</u>   |                                |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>CEREBROVASCULAR ACCIDENT</u>  |                              |  |  |  |                                | <u>6 DAYS</u>   |                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</u>   |                              |  |  |  |                                | <u>8 YEARS</u>  |                                |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                              |  |  |  |                                |   |                                |
| 19a. DATE OF OPERATION  |                              | 19b. MAJOR FINDINGS OF OPERATION   |  |  |                                | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                     |                                |   |                                |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>—</u>   |                              | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?   |                                |   |                                |
| 22. I hereby certify that I attended the deceased from <u>FEB</u> , 19 <u>49</u> , to <u>JAN</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10 JAN</u> , 19 <u>58</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above. |                              |  |  |  |                                |   |                                |
| SIGNATURE<br><u>H. P. Adair M.D.</u>  |                              |  |  | ADDRESS (Street, city, town, state)<br><u>401 Franklin St. Baltimore, Md.</u>                    |                                | DATE SIGNED<br><u>17 Jan 58</u>   |                                |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |                              | DATE THEREOF<br><u>Jan. 19, 1958</u>   |  | NAME OF CEMETERY OR CREMATORY<br><u>Centre Methodist Cemetery</u>                                |                                | LOCATION (City, town, or county) (State)<br><u>Forest Hill, Harf. Co., Maryland</u> |                                |
| 24. REC'D BY REGISTRAR  |                              | REGISTRAR'S SIGNATURE<br><u>Chas. L. Smith</u>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Joseph W. Foster</u>                                      |                                | ADDRESS<br><u>West Broadway Bel Air, Maryland</u>                                   |                                |
| DATE<br><u>JAN 21 '58</u>   |                              |  |  |  |                                |   |                                |

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

RECEIVED

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00750

## 758 CERTIFICATE OF DEATH

Reg. Dist. No. ....

|  |                               |  |                                   |   |                 |   |                  |
|--|-------------------------------|--|-----------------------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH  |                               |  |                                   | 2. USUAL RESIDENCE (HOME) OF DECEASED   |                 |   |                  |
| COUNTY <i>Harford</i>  |                               | MARYLAND   |                                   | STATE <i>Maryland</i> COUNTY <i>Harford</i>   |                 |   |                  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Aberdeen</i>   |                               | LENGTH OF STAY (In this place) <i>Lifetime</i>                         |                                   | CITY (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>           |                 |   |                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>R.F.W.#1 Bush Chapel Rd.</i>  |                               |  |                                   | STREET ADDRESS (If rural give location) <i>R.F.W.#1 Bush Chapel Rd.</i>                         |                 |   |                  |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>Walter Ray Warfield</i>   |                               |  |                                   | 4. DATE OF DEATH (Month) (Day) (Year) <i>1 24 19 58</i>   |                 |   |                  |
| 5. SEX <i>Male</i>   | 6. COLOR OR RACE <i>Negro</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>        | 8. DATE OF BIRTH <i>1-18-1908</i> | 9. AGE last birthday <i>50</i> yrs.   | IF UNDER 1 YEAR |   | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Taxi Driver</i>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <i>Aberdeen Moving Co.</i>           |                                   | 11. BIRTHPLACE (State or foreign country) <i>Harford Co. Maryland</i>                           |                 | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>                          |                  |
| 13. FATHER'S NAME <i>Walter Lee Warfield</i>   |                               |  |                                   | 14. MOTHER'S MAIDEN NAME <i>Susie Pitt</i>  |                 |   |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>  |                               | 16. SOCIAL SECURITY NO. <i>219-03-5202</i>                             |                                   | 17. INFORMANT & ADDRESS <i>R.F.W.#1 Bush Chapel Rd. Mrs. Maggie M. Warfield - Aberdeen, Md.</i> |                 |   |                  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                               |  |                                   |   |                 | INTERVAL BETWEEN ONSET AND DEATH                                      |                  |
| 1. IMMEDIATE CAUSE (A) <i>Acute Coronary Thrombosis</i>  |                               |  |                                   |   |                 |   |                  |
| 2. ANTECEDENT CAUSE(S) DUE TO  |                               |  |                                   |   |                 |   |                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO   |                               |  |                                   |   |                 |   |                  |
| 3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                               |  |                                   |   |                 |   |                  |
| 19a. DATE OF OPERATION   |                               | 19b. MAJOR FINDINGS OF OPERATION                                       |                                   |   |                 | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) |                                   | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                    |                 |   |                  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                               | 21f. HOW DID INJURY OCCUR?   |                                   |   |                 |   |                  |
| 22. I hereby certify that I attended the deceased from <i>12/30</i> , 19 <i>57</i> , to <i>1/24</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>1/24</i> , 19 <i>58</i> , and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above. |                               |  |                                   |   |                 |   |                  |
| SIGNATURE <i>George J. Stanbury</i>  |                               |  |                                   | ADDRESS (Street, city, town, state) <i>M.D. 569 Revolution St., Harford Co. Md.</i>             |                 | DATE SIGNED <i>1/27/58</i>  |                  |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |                               | DATE THEREOF <i>1-28-58</i>  |                                   | NAME OF CEMETERY OR CREMATORY <i>Union Methodist Cem.</i>                                       |                 | LOCATION (City, town, or county) <i>Aberdeen, Md.</i>                 |                  |
| 24. REC'D BY REGISTRAR <i>Alb. Leach</i>   |                               | REGISTRAR'S SIGNATURE  |                                   | 25. FUNERAL DIRECTOR'S SIGNATURE <i>Atelia G. Bullock</i>                                       |                 | ADDRESS <i>Harford Co. Md.</i>  |                  |
| DATE <i>JAN 2 1958</i>   |                               |  |                                   |   |                 |   |                  |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The same copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. B.

JAN 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

735 CERTIFICATE OF DEATH

Reg. Dist. No. 00751

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Harford</u>          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harne-de-Grace</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harne-de-Grace</u>                                     |  |
| c. LENGTH OF STAY IN 1b <u>24 hrs.</u>   |  | d. STREET ADDRESS <u>864 Erie ST. APT # 3</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Baby GIRL</u> First Middle Last   |  | 4. DATE OF DEATH <u>January 6, 19 58</u> Month Day Year   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/5/58</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME <u>Chester Joseph Warner</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Nancy Jane Powell</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT <u>Chester Warner</u> Address <u>864 Erie ST. City APT # 3</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cholesterin night lung</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>DUE TO (c) _____ |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) _____ (County) _____ (State) _____                         |
| 21. I certify that I attended the deceased from <u>Jan 5</u> , 19 <u>58</u> , to <u>Jan 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>58</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.                             |  |   |  |
| ACTUAL SIGNATURE <u>B. J. Plunkett Jr.</u> M.D.  |  | ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>1-6-58</u>   |  |
| NAME (Type) _____  |  |   |  |
| 22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>1-6-58</u>  | 22b. DATE THEREOF  | 22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>   | 22d. LOCATION (City, town, or county) <u>HARVE DE GRACE, MD.</u> (State) _____ |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Zully</u> Administrator   |  | 24a. REC'D BY REGISTRAR <u>JAN 15 58</u>  | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>                                  |



BUREAU V. S.

JAN 1

RECEIVED

736

## CERTIFICATE OF DEATH

00752

Reg. Dist. No.

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>HARFORD</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>HAUCE DE GRACE</u>  |   | c. LENGTH OF STAY IN 1b<br><u>17 DAYS</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>HARFORD MEMORIAL Hospital</u>   |   | e. STREET ADDRESS<br><u>WEST HALL</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>MOSES</u> Middle <u>JACOB</u> Last <u>WATTERS</u>  |   | 4. DATE OF DEATH<br>Month <u>JANUARY</u> Day <u>28</u> Year <u>1958</u>   |  |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>COLORED</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>MAR 7-1872</u>                                    |
| 9. AGE (In years last birthday)<br><u>85</u> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS<br>Months Days Hours Min.                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FRM WAGER</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>RETIRED</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>John Watters</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Nattie Watters</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)  |   | 16. SOCIAL SECURITY NO.<br><u>2-9-34-4784</u>   |  |
| 17. INFORMANT<br><u>William Watters</u>  |   | Address<br><u>FORESTHILL MD</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c) <u>Arteriosclerosis</u>   |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br>19  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                     |
| 21. I certify that I attended the deceased from <u>1/11</u> , 19 <u>58</u> , to <u>1/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/28</u> , 19 <u>58</u> , and that death occurred at <u>12:40</u> M, from the causes and on the date stated above.<br>A ADDRESS (Street, city or town, state) DATE SIGNED<br><u>George T. Stansbury</u> M.D. <u>569 Revolution St., Hauce de Grace, Md.</u> <u>1/28/58</u> |   |   |  |
| ACTUAL SIGNATURE<br><u>George T. Stansbury</u>   |   |   |  |
| PHYSICIAN'S NAME (Type)<br><u>George T. Stansbury</u>  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 22b. DATE THEREOF<br><u>JAN 31/58</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mountain Methodist</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>Joppa Harford Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Joseph T. Foster Bel Air Md</u>   |   | 24a. REC'D BY REGISTRAR<br>DATE <u>JAN 8 1959</u>   | 24b. REGISTRAR'S SIGNATURE<br><u>C. L. Smith</u>                         |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 10 1900

RECEIVED  
JAN 10 1900

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00753

R. Dist. No.

|  |                                     |   |   |
|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Hartford</u> MARYLAND  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>1</u>                              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Aberdeen</u>  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u> <u>Glen Burnie</u>                                     |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>101 W Court Road</u>  |                                     | d. STREET ADDRESS<br><u>606 Elizabeth Road</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Charles</u> Middle <u>Weir</u> Last <u>Weir</u>  |                                     | 4. DATE OF DEATH<br>Month <u>January</u> Day <u>10</u> Year <u>1958</u>   |   |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u>        | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 5, 1927</u>   |
| 9. AGE (in years last birthday)<br><u>30</u> yrs.  |                                     | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Electronic Technician</u>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Mid. Atlantic Jerrold Co</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore</u>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>  |   |
| 13. FATHER'S NAME<br><u>Charles H. Weir, Sr</u>  |                                     | 14. MOTHER'S MAIDEN NAME<br><u>Clara E. Labatue</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>yes</u>   |                                     | 16. SOCIAL SECURITY NO.<br><u>W. H. 11</u>  |   |
| 17. INFORMANT<br><u>Mrs. Clara E. Weir, 606 Elizabeth Road</u>   |                                     | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Electrocution</u><br><u>914.8</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>  </u><br>(c) <u>  </u>   |                                     |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>  </u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>  </u>   |                                     |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.<br><input type="checkbox"/>  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)<br><u>Repairing TV antenna &amp; touched live wire</u>          |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><u>1-10-58</u><br>Hour <u>  </u> Min <u>  </u> P. M. <u>  </u>  |                                     | 20d. INJURY OCCURRED<br>While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>101 W Court Road</u>  |                                     | 20f. (City or town) (County) (State)<br><u>Aberdeen</u> <u>Hartford</u> <u>MD</u>   |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . |                                     |   |   |
| ACTUAL SIGNATURE<br><u>Gerald C Palmer</u>   |                                     | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u>   |   |
| EXAMINER'S NAME (Type)<br><u>Gerald C Palmer MD</u>  |                                     | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>  </u>   |   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                     | DATE SIGNED<br><u>1-11-58</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 22b. DATE THEREOF<br><u>1-14-58</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Glen Haven Cemetery</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Ritchie Hwy., Glen Burnie</u>                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>William Cook, Inc., 1217 S. Paul Street</u>   |                                     | 24a. REC'D BY REGISTRAR<br><u>JAN 14 '58</u>  |   |
| ADDRESS  |                                     | 24b. REGISTRAR'S SIGNATURE<br><u>  </u>   |   |

THIS MEDICAL EXAMINER'S CERTIFICATE should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. File pages 1 and 2 with the medical examiner prior to burial, cremation, or removal.

30

4

BUREAU V. S.

JAN 14 1900

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 759 CERTIFICATE OF DEATH

00754

Reg. Dist. No. 180

|  |                              |  |   |  |   |  |                                |
|--|------------------------------|--|---|--|---|--|--------------------------------|
| 1. PLACE OF DEATH  |                              |  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED  |   |  |                                |
| COUNTY <u>HARFORD</u>  |                              | MARYLAND   |   | STATE <u>MARYLAND</u> COUNTY <u>BALT CO.</u>   |   |  |                                |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>Edgewood</u>   |                              | LENGTH OF STAY (in this place)<br><u>11 YEARS</u>  |   | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>BALTIMORE, MD.</u> |   | TOWN   |                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>Edgewood Road, Edgewood</u>  |                              |  |   | STREET ADDRESS (If rural give location)<br><u>1219 N. Charles St</u>                           |   |  |                                |
| 3. NAME OF DECEASED (Type or Print)<br><u>EVANGELINE HENDRICKS WISE</u>  |                              |  |   | 4. DATE OF DEATH<br>Month <u>JAN</u> Day <u>23</u> Year <u>1958</u>                            |   |  |                                |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)   | 8. DATE OF BIRTH<br><u>NOV 17, 1878</u> | 9. AGE last birthday<br><u>79</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>  |   | 11. BIRTHPLACE (State or foreign country)<br><u>VIRGINIA</u>                                   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>                                 |                                |
| 13. FATHER'S NAME<br><u>CHARLES A. Rew</u>   |                              |  |   | 14. MOTHER'S MAIDEN NAME<br><u>SALLY Bagwell ARKINGTON</u>                                     |   |  |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)<br><u>NO</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>NONE</u>   |   | 17. INFORMANT & ADDRESS<br><u>JOHNER, WISE Edgewood, Md.</u>                                   |   |  |                                |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                              |  |   |  |   | 18. MEDICAL CERTIFICATION  |                                |
| 5391 IMMEDIATE CAUSE (A) <u>G.I. BLEEDING</u>  |                              |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>4mo</u>                               |                                |
| ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>DILATION OF ESOPHAGUS, ETIOLOGY UNDETERMINED</u>   |                              |  |   |  |   | <u>7 YEARS</u>   |                                |
| (C) <u>HEART FAILURE, AURICULAR FIBRILLATION</u>   |                              |  |   |  |   | <u>4mo</u>   |                                |
| 19a. DATE OF OPERATION   |                              | 19b. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |  |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |   | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                   |   |  |                                |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)   |                              | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?   |   |  |                                |
| 22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>57</u> , to <u>JAN 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>NOV</u> , 19 <u>57</u> , and that death occurred at <u>5:35 P</u> , from the causes and on the date stated above. |                              |  |   |  |   |  |                                |
| SIGNATURE<br><u>Joseph P. Bertino</u>  |                              |  |   | ADDRESS (Street, city, town, state)<br><u>M.D. Box 905, Edgewood, Md</u>                       |   | DATE SIGNED<br><u>1/23/58</u>  |                                |
| 23. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                              | DATE THEREOF<br><u>JAN 26 1958</u>   |   | NAME OF CEMETERY OR CREMATORY<br><u>Belle Haven</u>  |   | LOCATION (City, town, or county) (State)<br><u>Belle Haven, Accomac, Va.</u> |                                |
| 24. REC'D BY REGISTRAR<br><u>JAN 29 58</u>   |                              | REGISTRAR'S SIGNATURE<br><u>Alb...</u>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Howard P. Thomas</u>                                    |   | ADDRESS<br><u>Abingdon, Md.</u>  |                                |

# CERTIFICATE OF DEATH

NEW YORK

IN SENATE, JANUARY 23, 1933

REPORTED BY

DATE

PLACE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

CAUSE OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

BUREAU V. S.

JAN 23 1933

RECEIVED

760

Item 9 Film 225 2-3-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 40755

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Harford</u>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rocks</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rocks</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |   | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) First <u>NADMI</u> Middle <u>Cooper</u> Last <u>Zink</u>  |   | 4. DATE OF DEATH Jan 27 1958   |   |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept 16 1890 67 yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>  | 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>                 |
| 13. FATHER'S NAME <u>John Edson Foist</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Emma Cooper</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)  |   | 16. SOCIAL SECURITY NO. <u>315-03-2069B</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>331X</u><br>DUE TO (b) <u>CEREBROVASCULAR ACCIDENT</u><br>DUE TO (c) <u>HYPERTENSION &amp; PREVIOUS CVA'S</u> |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 DAYS</u><br><u>10 DAYS</u><br><u>20 YEARS</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>  |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>—</u> p. m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>APR. 1950</u> , to <u>26 JAN 1958</u> , that I last saw the deceased alive on <u>26 JAN 58</u> , and that death occurred at <u>1:20 P. M.</u> from the causes and on the date stated above.    |   |  |   |
| ACTUAL SIGNATURE <u>H. P. Sidwell</u> M.D.  |   | ADDRESS (Street, city or town, state) <u>401 Franklin, Baltimore</u> DATE SIGNED <u>27 Jan 58</u>  |   |
| PHYSICIAN'S NAME (Type) <u>H. P. SIDWELL M.D.</u>   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>Jan 30 1958</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Donald Ridge</u>   | 22d. LOCATION (City, town, or county) (State) <u>Pikesville Baltimore Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey W. Jenkins</u> ADDRESS <u>Ann Co 4905 York Rd</u>  |   | 24a. REC'D BY REGISTRAR  | 24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>                                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU OF VITAL RECORDS

8961 Jan 29 1958

RECEIVED